



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 23, 2021

Administrator
Regina Senior Living
1175 Nininger Road
Hastings, MN 55033

RE: CCN: 245254
Cycle Start Date: July 29, 2021

Dear Administrator:

On July 29, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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:

Sarah Grebenc, 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: sarah.grebenc@state.mn.us
Office: (651) 201-3792

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 October 29, 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 January 29, 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/lrc_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

Regina Senior Living

August 23, 2021

Page 4

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
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

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

PRINTED: 09/09/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/29/2021
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD HASTINGS, MN 55033		
(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
E 000	Initial Comments On 7/26/21 through 7/29/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance.	E 000			
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. On 7/26/21 through 7/29/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be unsubstantiated: H5254042C (MN59605), H5254043C (MN62536), H5254045C (MN72602), H5254046C (MN44128). The following complaints were found to be substantiated without deficiency due to actions implemented by the facility prior to survey: H5254044C (MN72518), H5254047C (MN69423). Additionally, on 7/26/21 through 7/29/21, a COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined to be not in compliance.	F 000			

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

TITLE

(X6) DATE

Electronically Signed

08/31/2021

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.

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

PRINTED: 09/09/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/29/2021
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD HASTINGS, MN 55033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	Continued From page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000			
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to have a call light within reach for 1 of 2 residents (R7) who was dependent and needed staff assistance for daily care needs. Findings include: R7's annual Minimum Data Set (MDS) assessment dated 5/11/21, indicated a diagnosis of non-traumatic brain dysfunction. The MDS further indicated R7 had severe cognitive impairment based on a brief inventory of mental status (BIMS) score of six. The MDS indicated R7	F 558	R7 had clip added to call light on 7/28/21. In house audit was completed on all residents to ensure each resident had a call light, with a clip attached and within reach on 7/28/21. Education will be provided to all nursing staff regarding call light system and facility's TELs program to report any call light issues. Audits will be conducted 5X a week for 3 weeks, and results will be brought to QA to be reevaluated. Director of Nursing or designee are responsible for compliance.		9/6/21

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

PRINTED: 09/09/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/29/2021
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD HASTINGS, MN 55033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 558	Continued From page 2 required extensive assist from staff bed mobility, transfers, dressing, eating and toileting. Also, R7 had no impairment in functional range of motion in his upper extremities. R7's care plan dated 7/7/21, directed the staff to ensure R7's call light was within reach while in room. During observation on 7/27/21, at 3:59 p.m. R7 was observed to sit in his wheelchair in his room. R7's call light was on the floor by his bed. There was no clip observed on the call light to secure it to a location in reach. R7 tried to speak but the words were undiscernible. During interview and observation on 7/27/21, at 4:02 p.m. registered nurse (RN)-C stated R7 would sometimes use his call light. RN-C entered R7's room and stated he could not have reached his call light on the floor. RN-C picked up the call light and put it in R7's hand. RN-C asked R7 what he needed and then determined he wanted to go out to the dining room. During observation on 7/28/21, at 10:51 a.m. R7 sat in his wheelchair in his room. R7's call light was at the foot of his bed coiled up next to the wall. There was no clip observed on the call light to secure it to a location in reach. R7 tried to speak but the words were undiscernible. During interview and observation on 7/28/21, at 11:19 a.m. nursing assistant (NA)-A entered R7's room and stated call lights should be within reach. NA-A stated R7 could not have reached his call light at the foot of his bed. NA-A picked up the call light and put it in R7's hand. NA-A asked R7 what he needed and then determined	F 558	Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results.		

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

PRINTED: 09/09/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/29/2021
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD HASTINGS, MN 55033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 558	Continued From page 3 he wanted to get turned around in his wheelchair. During interview on 7/28/21, at 11:23 a.m. RN-B reviewed R7's care plan and stated his call light should be within reach. During interview on 7/28/21, at 12:59 p.m. the director of nursing (DON) stated R7's call light should be within his reach. The facility policy Call Light Response last revised 3/17, directed staff to position the call light conveniently for the resident to use and tell the resident where the call light is prior to leaving the room.	F 558			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure shaving and nail care was provided for 1 of 1 residents (R32) who was dependent upon staff for assistance with activities of daily living (ADLs). Findings include: R32's significant change Minimum Data Set (MDS) dated 6/25/21, indicated R32 was severely cognitively impaired. R32 was fully dependent on staff for eating, oral hygiene, toileting, showering, and dressing. R32 was always incontinent of bladder and bowel and required assist of two staff	F 677	R32 had nail care completed and was shaved on 7/29/21. Facility audit was conducted on 08/26/21 for nail care and shaving. Education will be provided to all nursing staff regarding resident hygiene including nail trimming and shaving. Audits will be conducted weekly for 3 weeks, and results will be brought to QA to be reevaluated. Director of Nursing or designee are responsible for compliance. Results of monitoring shall be reported at the facility Quality Council meeting with		9/6/21

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

PRINTED: 09/09/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/29/2021
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD HASTINGS, MN 55033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 677	Continued From page 4 for bed mobility and transfers. The MDS indicated R23 had diagnoses of right-sided paralysis, seizures, heart failure, respiratory failure, and diabetes. R32's care plan dated 7/8/21, identified ADLs as a problem area and indicated staff were to shave R23 on bath day, and nursing was expected to trim R32's fingernails and toenails as needed following his weekly bath. A progress note dated 7/26/2021, at 12:00 p.m. reported R32's family member (FM)-A expressed concern over his long hair, bathing, and overall grooming. The concerns were brought to the attention of the nurse manager who informed FM-A that R32 was placed on the list for a haircut, and scheduled for a bath on 7/27/21. During observation on 7/26/21, at 1:15 p.m. R23 sat in his reclining wheelchair in his room. His hair was approximately 10 inches in length, and he had facial hair of approximately 3/8 inch. His fingernails were approximately 1/4 inch in length and curved slightly around over his fingertips. Brown dirt-like substance was visible under his fingernails. During interview on 7/26/21, at 3:25 p.m. FM-A stated she visited that morning and he looked like he had not had a haircut for three months and his facial hair was very long. She expressed R32 would not want his hair that long and he would want to be shaved. She stated his nails needed to be clipped on his hands and feet, and "he would have wanted them done". R32's Weekly Bath Sheet dated 7/27/21, indicated R32 had a bed bath, but lacked	F 677	ongoing frequency and duration to be determined through analysis and review of results.		

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

PRINTED: 09/09/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/29/2021
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD HASTINGS, MN 55033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 677	Continued From page 5 documentation of shaving and nail trimming. During observation on 7/28/21, at 7:18 a.m. R32 laid in bed. His fingernails were not trimmed nor his face shaved. During observation on 7/29/21, at 8:24 a.m. R32 sat at the dining room table. His fingernails were not trimmed nor his face shaved. During interview on 7/29/21, 8:26 a.m. registered nurse (RN)-A stated nurses would shave a resident if the aides did not. She stated fingernails were clipped by nursing assistants after showers or baths unless the resident was diabetic or on a blood thinner, in which case nurses clipped them. She stated there was someone who came into the facility weekly to cut residents' hair if requested, and if staff noticed a resident's hair was longer they would ask the resident or the family if they wanted it cut. She stated they had a list of residents who requested haircuts. She specified nail trimmings were marked on the Weekly Bath Sheet or in a progress note, and there were a couple of residents who had shaving in their care plan, but otherwise it was not formally documented. During interview on 7/29/21, at 9:39 a.m. licensed practical nurse (LPN)-D stated nurses shaved most residents on shower days, and some had orders for shaving. She stated R32 should have had something in his room to use for shaving which the aides could have used. She stated fingernails were also done on shower days and as needed, and documentation of shaving and nail trimming was documented either on the Weekly Bath Sheet or in a progress note.	F 677			

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

PRINTED: 09/09/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/29/2021
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD HASTINGS, MN 55033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page 6 Further review of R32's Weekly Bath Sheets indicated the following: -On 7/20/21, R32 had a bed bath but was not shaved nor were his nails trimmed. -On 7/13/21, R32 had a shower, but lacked documentation of shaving and nail trimming. -On 7/6/21, the bath sheet lacked documentation of bath or shower, shaving, and nail trimming. -On 6/29/21, R32 had a shower, but lacked documentation of shaving and nail trimming. During interview on 7/29/21, at 1:02 p.m. the director of nursing (DON) stated if staff noticed a resident had long fingernails they should have been clipped. She stated hair should be kept to residents preference, and staff needed to anticipate the need if a resident couldn't express their needs. DON stated staff documented if nails were cut and if the resident was shaved on the Weekly Bath Sheet. She stated if it looked like it needed to be done, it should have been done, and it was scheduled on bath day so that it was done at least weekly. DON stated if family brought up an issue with grooming she would address it right away and take care of it herself if she needed to. She stated her expectation was someone would have addressed it right away. DON reviewed R32's bath sheets and was unable to identify when he was last shaved or had his nails trimmed. On 7/29/21, at 1:08 p.m. DON viewed R23 in his room and stated, "He definitely needs a shave if it's not his preference." She further stated his fingernails needed to be cut "for sure", and described his nails as "dirty".	F 677			
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684			9/6/21

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

PRINTED: 09/09/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/29/2021
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD HASTINGS, MN 55033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page 7 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide appropriate medical device monitoring for 1 of 1 resident (R36) reviewed for quality of care. Findings include: R36's quarterly Minimum Data Set (MDS) dated 7/6/21, indicated R36 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated R36 was cognitively intact. R36's diagnoses included ventricular tachycardia (the lower chambers of the heart beat rapidly), chronic systolic congestive heart failure (the heart doesn't pump blood adequately) and atrioventricular block (interruption of pulses throughout the heart). R36's admission assessment dated 8/22/18, verified a pacemaker was in place upon admission. Interview on 7/29/21, at 10:39 a.m. family member (F)-A reported on 1/19/21, she received a letter from Allina Health that indicated R36's pacemaker transmitter did not transmit data to them. F-A notified the facility about the letter and	F 684	R36 is no longer in facility. Audit was completed on 08/03/21 to determine all residents with pace makers. Education was provided on 08/04/21 to the nursing administration regarding competition of routine pace maker checks. Monitoring device for pace maker was added to all residents plan of care. Audits will be conducted 5X a week for 3 weeks, and results will be brought to QA to be reevaluated. Director of Nursing or designee are responsible for compliance. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results.		

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

PRINTED: 09/09/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/29/2021
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD HASTINGS, MN 55033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page 8 spoke with a staff member, F-A was unable to recall staff member's name. F-A was assured the message would be forwarded to the nurse manager. F-A visited facility on 1/24/21, and noticed the transmitter was in the R36's closet and not plugged in. F-A reported R36 had the pacemaker since 5/2018, and had been hooked up in her room since that time. She reported Allina could only verify the machine had been disconnected for at least two weeks. Upon interview on 7/29/21, at 8:33 a.m. registered nurse (RN)-A reported that R36 didn't have a monitor, but she had a follow-up with a cardiologist. She reported if R36 had a monitor, it would be noted in the medical record. Upon observation on 7/29/21, at 11:19 a.m. R36's transmitter was not visible. R36 pointed out where the transmitter was, behind a pile of papers and cards on a shelf near her bed. The transmitter was plugged in. Upon interview on 7/29/21, at 11:45 a.m. trained medication assistant (TMA)-A reported she has never seen a transmitter in the room. Upon interview on 7/29/21, at 11:34 a.m. registered nurse (RN)-B verified the pacemaker was indicated on the admission observation, however RN-B reported nothing was on the plan of care and RN-B was unaware R36 had a pacemaker or a transmitter. RN-B stated that safety wise the facility should be responsible to make sure it is plugged in. Upon interview on 7/29/21, at 11:48 am. the director of nursing (DON) reported the facility	F 684			

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

PRINTED: 09/09/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/29/2021
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD HASTINGS, MN 55033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page 9 needs to be aware of who has a pacemaker, how it checked, were and when it is checked and who to contact to troubleshoot if needed. The DON stated a transmitter should be checked pre shift and that all departments need to be aware of the equipment and what to do it with it from their perspective. The DON was unaware that R36 had a pacemaker and a transmitter. Medical Devices policy dated 5/2020, indicated that residents are assessed to ensure their needs are being met. Residents identified in need of medical devices have interventions/equipment implemented in accordance wit the resident centered care plan. The facility follows medical device manufacturers guidelines for use. The facility follows manufacturer recommendations for safe handling, cleaning, and storage, maintenance of equipment in accordance with the manufacturer specifications and consistent with federal, state and local laws and regulations. The facility ensures in the event of a power loss, necessary medical device is plugged into emergency outlets if required.	F 684			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880			9/6/21

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

PRINTED: 09/09/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/29/2021
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD HASTINGS, MN 55033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	Continued From page 10 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed	F 880			

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

PRINTED: 09/09/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/29/2021
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD HASTINGS, MN 55033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page 11 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure personal protective equipment (PPE) was used when direct care was provided for 1 of 1 resident (R41) who required isolation precautions. In addition, the facility failed to ensure equipment in room was disinfected following contamination. Findings include: R41's annual Minimum Data Set (MDS) dated 12/01/20, indicated R41 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. Diagnoses included traumatic subdural hemorrhage (acute brain injury), pressure ulcer of sacral region, stage 3 (open wound, on the lower back region, with sores extending into the tissue), methicillin resistant staphylococcus aureus infection, (bacteria severely difficult to treat in humans), and aphagia (loss of ability to express speech caused by brain injury).	F 880	- Root Cause Analysis was completed to identify areas which results in deficiency and was completed on 8/27/2021 - Action Plan was completed to prevent reoccurrences of problem areas identified in RCA and was completed on 9/8/2021 - Root Cause Analysis and Action Plan were reviewed and approved by Quality Council on 8/27/2021 and 9/9/2021. - PPE donning and doffing sequence sheets for employee reference and utilization to be hung in isolation rooms to ensure proper donning/doffing technique and was completed on 9/8/2021 - R41 PPE to be stored with dressing supplies in resident's room and was completed on 9/8/2021. - All Staff Mandatory Policy Review and Education/competencies: - Review Policy: Standard Precautions POL_IP052 - Review Policy: Contact Precautions		

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

PRINTED: 09/09/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/29/2021
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD HASTINGS, MN 55033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	Continued From page 12 R41's care plan dated 5/19/21, identified a self-care deficit and directed staff to assist with activities of daily living that included bathing, grooming, oral cares, transferring, mobility, vision, bowel and bladder, with assistance of 1, and required an EZ stand with all transfers. R41's care plan indicated isolation precautions per policy. Observation on 7/28/21, at 10:32 identified an isolation sign that was on the door. Staff were directed to wear gown, gloves, mask and eye protection. A biohazard bin was placed outside the door and a cart with PPE was outside the door. During an observation on 7/28/21, 10:32 a.m. registered nurse (RN)-A completed the wound care tasks and then moved R41's tray table next to his bed, touched the top surface of the table with soiled gloves. RN-A did not disinfect the table following the contamination. During an observation on 7/28/21, at 10:40 a.m. nursing assistant (NA)-A assisted R41 to the toilet toilet and did not wear a gown or gloves. During an interview on 7/28/21, at 10:48 a.m. NA-A verified that with all hands-on care in the isolation room a gown and gloves must be worn. During an interview on 7/29/21, at 9:03 a.m. RN-A verified the tray table was moved with soiled gloves. RN-A stated the infection control protocol was to doff all (PPE) and wash hands prior to touching any surface in the room. If the surface was contaminated it needed to be disinfected. During an interview on 7/29/21, at 9:58 a.m. the	F 880	POL_IP057 - o Review Policy: Hand Hygiene POL_IP054 - o Review Policy: Resident Care Equipment POL_IP014 - o Review Policy: Guidelines for MRSA POL_IP048 - o Review Handout: CDC Use PPE When Caring for Patients with Confirmed or Suspected COVID-19 for Donn/Doff PPE ***Competencies to be used as post-test*** • Handwashing Audits and competency testing will be completed 4X a week on all shifts for one week, then twice weekly for 1 week once compliance is met. • Donning & Doffing Audits and competency testing will be completed 4X a week on all shifts for one week, then twice weekly for 1 week once compliance is met. • Disinfection of shared equipment audits 4x a week on all shifts for one week, then twice weekly for 1 week once compliance is met. • The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.		

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

PRINTED: 09/09/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/29/2021
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD HASTINGS, MN 55033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	Continued From page 13 director of nursing (DON) stated the policy for a lapse in PPE, if soiled gloves touch a clean surface, was staff should immediately doff all PPE, wash hands, redress in clean PPE and disinfect surface with approved disinfectant. Contact Precaution policy dated 06/21, indicated hand hygiene is done prior to donning PPE. PPE is donned prior to entering room, gloves, gown, goggles, and face mask. The handling of resident-care equipment and devices are cleaned with facility disinfectants as indicated routinely and when contaminated.	F 880			

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

F5254030

PRINTED: 09/21/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NURSING HOME B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2021	
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD HASTINGS, MN 55033			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/28/2021. At the time of this survey, REGINA SENIOR LIVING 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

08/31/2021

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.

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

PRINTED: 09/21/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NURSING HOME B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2021
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD HASTINGS, MN 55033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	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. REGINA SENIOR LIVING is a 1-story building with full basement. It was constructed in 1965 and was determined to be of Type II (111) construction. In 2012, a TCU was added to the building, having a 2-hr fire separation and determined to be Type II (111) construction. Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of	K 000			

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

PRINTED: 09/21/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NURSING HOME B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2021
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD HASTINGS, MN 55033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	Continued From page 2 National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and resident rooms, that is monitored for automatic fire department notification. The facility has a capacity of 57 beds and had a census of 43 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000			
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 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	K 324		7/29/21	

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

PRINTED: 09/21/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NURSING HOME B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2021
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD HASTINGS, MN 55033		
(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 324	Continued From page 3 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 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper safety and security related to a cooking device in a resident accessible corridor in accordance with the Life Safety Code NFPA 101, 2012 edition, section 19.3.2.5.3. This deficient condition could have an isolated impact on the residents within the facility. Findings Include: On 07/28/2021 between 09:00 AM to 02:00 PM, it was revealed during the walk-through of the facility that in the Physical Therapy / Occupational Therapy Room, the stove control switch, on the wall adjacent to the stove, was a twist-turn switch - having no lock-out capabilities or means to secure This deficient condition was confirmed by the Facility Administrator at the time of discovery.	K 324	The issue has been corrected by installing a lock box over the switch and will be locked out when not supervised by therapy staff. All therapy staff have been educated of the update / change. Lock box will be audited weekly X 4 weeks. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Complete Date: 9/17/21		
K 353 SS=D	Sprinkler System - Maintenance and Testing 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,	K 353			9/30/21

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

PRINTED: 09/21/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NURSING HOME B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2021
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD HASTINGS, MN 55033		
(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 353	Continued From page 4 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, staff interview and documentation review, 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 5.2.1.1, 5.2.1.1.3, 5.2.1.2. NFPA13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 8.1.1, 8.5.4.1, 22.1 These deficient conditions could have an isolated impact on the residents within the facility. Findings include: 1. On 07/28/2021 between 09:00 AM to 02:00 PM, it was revealed during walk-through of the facility that a portion of the ceiling directly above the fire sprinkler system and sprinkler heads in the Physical Therapy Area, located in the basement, was missing. The absence of the amount of finished ceiling viewed, could result in delayed activation of sprinkler heads and	K 353	The ceiling has been repaired by a certified contractor. All ceiling tiles have been replaced and ceiling is back to intended condition. Any future issues will be reported to the maintenance department and repaired immediately upon discovery. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Complete Date: 9/30/21		

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

PRINTED: 09/21/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NURSING HOME B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2021
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD HASTINGS, MN 55033		
(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 353	Continued From page 5 sprinkler system in the event of a fire in that area. 2. On 07/28/2021 between 09:00 AM to 02:00 PM, it was revealed during staff interview that the missing ceiling directly above the fire sprinkler system and sprinkler heads in the Physical Therapy Area, located in the basement, was part of a sprinkler system upgrade. During documentation review no working plans associated to the sprinkler system were presented for review -or- an associated timeline of project completion These deficient conditions were confirmed by the Facility Maintenance Director at the time of discovery.	K 353			
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 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 18/19.2.2. 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 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to properly document the evacuation and relocation plan in accordance with	K 711	Instructions have been added to the fire plan that the charge nurse will call 911 in the event of a fire emergency. The		7/29/21

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

PRINTED: 09/21/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NURSING HOME B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2021
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD HASTINGS, MN 55033		
(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 711	Continued From page 6 the Life Safety Code NFPA 101, 2012 edition, sections 19.7.2, 19.7.2.1.2, 19.7.2, 19.7.2.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 07/28/2021 between 09:00 AM to 02:00 PM, it was revealed during documentation review that the Fire Safety Plan was missing informational content associated to notification of the fire department (call 9-1-1), as-well-as plans and routes whereby resident would be relocated or evacuated from the facility (floor-plan with routes and points of egress) This deficient condition was confirmed by the Maintenance Director at the time of discovery.	K 711	evacuation routes have been added to the fire plan. This will be included in the annual review of the EOP to ensure all routes and procedures are up to date.		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 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 less than or equal to 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 less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the	K 914			9/17/21

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

PRINTED: 09/21/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NURSING HOME B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2021
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD HASTINGS, MN 55033		
(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 914	Continued From page 7 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) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to properly document the annual electrical receptacle testing in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.3.3.2, 6.3.4.1 and 6.3.4.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 07/28/2021 between 09:00 AM to 02:00 PM, it was revealed during documentation review the records provided for review were generic in information content, not providing detailed information associated to the duplex and/or quad outlets located in resident rooms This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 914	The annual receptacle inspection document has been updated to include the date the testing is completed, a sign off of who is completing testing and has each outlet gang properly labeled. Outlet testing has been added to facility's TELs program, as testing will be completed on an annual basis. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Complete Date: 9/17/21		
K 923 SS=F	Gas Equipment - Cylinder and Container Storage 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	K 923			9/17/21

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

PRINTED: 09/21/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NURSING HOME B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2021
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD HASTINGS, MN 55033		
(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 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. 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 and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.4, 11.6.5 This deficient condition could have an widespread impact on the residents within the facility. Findings include: On 07/28/2021 between 09:00 AM to 02:00 PM, it	K 923	All oxygen cylinders which are not tagged as full will be put into the empty rack. Both full and empty racks are identified with signage. Additionally, all oxygen cylinders will be returned from the agency they came from when no longer required. After entering the facility, residents are provided with liquid oxygen only. All nursing staff have been educated on		

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

PRINTED: 09/21/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NURSING HOME B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2021
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD HASTINGS, MN 55033		
(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 was revealed that the Med Gas Storage Room had mixed storage of cylinders and there was no in-room signage to identify placement location for empty / full cylinders This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 923	proper oxygen storage. Audits to ensure proper storage compliance will be conducted weekly X 4 weeks. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Complete Date: 9/17/21		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WOQ3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00100

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245254		3. NAME AND ADDRESS OF FACILITY (L3) REGINA SENIOR LIVING (L4) 1175 NININGER ROAD (L5) HASTINGS, MN (L6) 55033		4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint	
2.STATE VENDOR OR MEDICAID NO. (L2) 012198100		5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 01/01/2014		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (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	
6. DATE OF SURVEY 07/29/2021 (L34)		8. ACCREDITATION STATUS: <u> </u> (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other		FISCAL YEAR ENDING DATE: (L35) 06/30	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10.THE FACILITY IS CERTIFIED AS: A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements <u> </u> 2. Technical Personnel <u> </u> 6. Scope of Services Limit Compliance Based On: <u> </u> 3. 24 Hour RN <u> </u> 7. Medical Director <u> </u> 1. Acceptable POC <u> </u> 4. 7-Day RN (Rural SNF) <u> </u> 8. Patient Room Size <u> </u> 5. Life Safety Code <u> </u> 9. Beds/Room X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B* (L12)			
12.Total Facility Beds 57 (L18)		13.Total Certified Beds 57 (L17)		14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 57 (L37) (L38) (L39) (L42) (L43)	
		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)			

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

17. SURVEYOR SIGNATURE Sara Freking, HFE NE II (L19)		Date : 09/21/2021		18. STATE SURVEY AGENCY APPROVAL Kamala Fiske-Downing, Enforcement Specialist (L20)		Date: 10/06/2021	
---	--	--------------------------	--	--	--	-------------------------	--

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

19. DETERMINATION OF ELIGIBILITY <u> </u> 1. Facility is Eligible to Participate <u> </u> 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 : <u> </u>	
22. ORIGINAL DATE OF PARTICIPATION 06/02/1982 (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) <u>VOLUNTARY</u> 00 <u>INVOLUNTARY</u> 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active	
28. TERMINATION DATE: (L28)		29. INTERMEDIARY/CARRIER NO. 00000 (L31)		30. REMARKS	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE (L33)		DETERMINATION APPROVAL	



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

Standard Survey Date Format: mm/dd/yy From F1: 07/26/21 To F2: 07/29/21		Extended Survey Date Format: mm/dd/yy From F3: To F4:	
Name of Facility: REGINA SENIOR LIVING		Provider Number: 245254	Fiscal Year ending:
Address: 1175 NININGER ROAD, HASTINGS, DAKOTA, MN 55033			
Telephone Number: F6 651-480-4333		State/County Code: MN / DAKOTA	State/Region Code: MN / 05
A. F9 03 - SNF/NF - Medicare/Medicaid B. Is this facility hospital based? F10 No If yes, indicate Hopsital Provider Number: F11 NA			
Ownership: F12 04 - Non Profit - Church Related			
Owned or leased by Multi-Facility Organization: F13 Yes Name of Multi-Facility Organization: F14 Benedictine			
Dedicated Special Care Units (show number of beds for all that apply)			
AIDS F15 0		Alzheimer's Disease F16 0	
Dialysis F17 0		Disabled Child Young Adult F18 0	
Head Trama F19 0		Hospice F20 0	
Huntington's Disease F21 0		Ventilator/Respiratory Care F22 0	
Other Spec Rehab. F23 0			
Does the facility currently have an organized resident group? F24			Yes
Does the facility currently have an organized group of family members of			Yes

residents? F25								
Does the facility conduct experimental research? F26		No						
Is the facility part of a continuing care retirement community (CCRC)? F27		Yes						
If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of the last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks. <table> <tr> <td>Waiver of seven day RN requirement.</td> <td>Date: mm/dd/yy F28 NA</td> <td>Hours waived per week: F29 NA</td> </tr> <tr> <td>Waiver of 24 hr licensed nursing requirement.</td> <td>Date: mm/dd/yy F30 NA</td> <td>Hours waived per week: F31 NA</td> </tr> </table>			Waiver of seven day RN requirement.	Date: mm/dd/yy F28 NA	Hours waived per week: F29 NA	Waiver of 24 hr licensed nursing requirement.	Date: mm/dd/yy F30 NA	Hours waived per week: F31 NA
Waiver of seven day RN requirement.	Date: mm/dd/yy F28 NA	Hours waived per week: F29 NA						
Waiver of 24 hr licensed nursing requirement.	Date: mm/dd/yy F30 NA	Hours waived per week: F31 NA						
Does the facility currently have an approved nurse aide training and competency program? F32		No						
The following three questions are to be completed by the survey team. 1) Was this a staggered Survey? No - Not Staggered 2) If staggered, day of the week starting? Surveyor to Complete 3) If staggered, starting time? Surveyor to complete AM								
Name of Person Completing Form: Briana Sturm		Date: 07/30/21						

- [Share This](#)

Spotlight

[Minnesota eLicensing](#)

Questions?

Please contact our Health Regulation Division: health.fpc-web@state.mn.us or 651-201-4101.

See also > [Health Regulation](#)

- [Certificates & Records](#)
- [Data & Statistics](#)
- [Diseases & Conditions](#)
- [Emergency Preparedness](#)
- [Environments & Your Health](#)
- [Facilities & Professions](#)
- [Health Care & Coverage](#)
- [Injury, Violence & Safety](#)
- [Life Stages & Populations](#)
- [Policy, Economics & Legislation](#)
- [Prevention & Healthy Living](#)



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

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

REGINA SENIOR LIVING

Provider No.	Medicare F75	Medicaid F76	Other F77	Total Residents F78
245254	2	30	11	43

ADL	Independent	Assist of One Two Staff	Dependent
Bathing	F79 1	F80 40	F81 2
Dressing	F82 2	F83 39	F84 2
Transferring	F85 2	F86 33	F87 8
Toilet Use	F88 2	F89 38	F90 3
Eating	F91 12	F92 29	F93 2

A. Bowel/Bladder Status

F94 **2** With indwelling or external catheter.

F95 Of total number of residents with catheters, **1** were present on admission.

F96 **39** Occasionally or frequently incontinent of bladder.

F97 **31** Occasionally or frequently incontinent of bowel.

F98 **39** On individually written bladder training program.

B. Mobility

F100 **1** Bedfast all or most of time..

F101 **39** In chair all or most of time.

F102 **1** Independently ambulatory.

F103 **17** Ambulation with assistance or assistive device.

F104 **0** Physically restrained.

F99 **29** On individually written bowel training program.

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

F106 **24** With contractures.

F107 Of total number of residents with contractures, **19** had contractures on admission.

C. Mental Status

F108 **0** With mental retardation.

F109 **18** With documentation signs and symptoms of depression.

F110 **12** With documentation psychiatric diagnosis (excluding dementias and depression).

F111 **16** Dementia: multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type.

F112 **3** With behavioral symptoms.

F113 **3** Of the total number of residents with behavioral symptoms, the total number receiving a behavior management program.

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

D. Skin Integrity

F115 **4** With pressure sores (exclude stage I).

F116 **2** Of the total number of residents with pressure sores excluding stage I, how many residents had pressure sores on admission?

F117 **17** Receiving preventive skin care.

F118 **11** With rashes.

E. Special Care

F119 **5** Receiving hospice care benefit.

F120 **0** Receiving radiation therapy.

F121 **0** Receiving chemotherapy.

F122 **0** Receiving dialysis.

F123 **0** Receiving intravenous therapy, parenteral nutrition, and/or blood transfusion.

F124 **8** Receiving respiratory treatment.

F125 **0** Receiving tracheostomy care.

F126 **1** Receiving ostomy care.

F127 **1** Receiving suction.

F128 **8** Receiving injections (exclude vitamin B12 injections)

F129 **1** Receiving tube feedings.

F130 **8** Receiving mechanically altered diets including pureed and all chopped food (not only meat).

F131 **13** Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy).

F132 **2** Assistive devices while eating.

F. Medication F133 22 Receiving any psychoactive medication. F134 4 Receiving antipsychotic medications. F135 7 Receiving antianxiety medications. F136 17 Receiving antidepressant medications. F137 0 Receiving hypnotic medication. F138 2 Receiving antibiotics. F139 37 On pain management program.	G. Other F140 8 With unplanned significant weight loss/gain. F141 0 Who do not communicate in the dominant language of the facility (includes those who use sign language). F142 0 Who use non-oral communication devices. F143 27 With advance directives. F144 37 Received influenza immunization. F145 42 Received pneumococcal vaccine.
---	--

I certify that this Information is accurate to the best of my knowledge.		
Name of Person Completing	Title	Date
Charlotte Cameron	Director of Nursing	07/30/2021

To be completed by MDH survey team.
F146 Was ombudsman office notified prior to survey? Yes
F147 Was ombudsman present during any portion of the survey? Yes
F148 Medication error rate 0%

- [Share This](#)

Spotlight

[Minnesota eLicensing](#)

Questions?

Please contact our Health Regulation Division: health.fpc-web@state.mn.us or 651-201-4101.

See also > [Health Regulation](#)

- [Certificates & Records](#)
- [Data & Statistics](#)
- [Diseases & Conditions](#)
- [Emergency Preparedness](#)
- [Environments & Your Health](#)

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

PROVIDER NUMBER K1 245254	FACILITY NAME REGINA SENIOR LIVING	SURVEY DATE *K4 07/28/2021
---	--	--

K6 DATE OF PLAN APPROVAL	<table style="width: 100%;"> <tr> <td style="width: 60%;"> K3 : MULTIPLE CONSTRUCTION TOTAL NUMBER OF BUILDINGS <u>1</u> NUMBER OF THIS BUILDING <u>01</u> </td> <td style="width: 40%; text-align: center; vertical-align: middle;"> A </td> </tr> </table>	K3 : MULTIPLE CONSTRUCTION TOTAL NUMBER OF BUILDINGS <u>1</u> NUMBER OF THIS BUILDING <u>01</u>	A
K3 : MULTIPLE CONSTRUCTION TOTAL NUMBER OF BUILDINGS <u>1</u> NUMBER OF THIS BUILDING <u>01</u>	A		

A BUILDING
 B WING
 C FLOOR
 D APARTMENT UNIT

LSC FORM INDICATOR <table border="1" style="width: 100%; border-collapse: collapse; margin-bottom: 5px;"> <tr><th colspan="3">Health Care Form</th></tr> <tr><td style="width: 10%;">12</td><td style="width: 50%;">2786 R</td><td style="width: 40%;">2012 EXISTING</td></tr> <tr><td>13</td><td>2786 R</td><td>2012 NEW</td></tr> </table> <table border="1" style="width: 100%; border-collapse: collapse; margin-bottom: 5px;"> <tr><th colspan="3">ASC Form</th></tr> <tr><td>14</td><td>2786 U</td><td>2012 EXISTING</td></tr> <tr><td>15</td><td>2786 U</td><td>2012 NEW</td></tr> </table> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><th colspan="3">ICF/MR Form</th></tr> <tr><td>16</td><td>2786 V, W, X</td><td>2012 EXISTING</td></tr> <tr><td>17</td><td>2786 V, W, X</td><td>2012 NEW</td></tr> </table> *K7 12 SELECT NUMBER OF FORM USED FROM ABOVE <i>(Check if K321 or K351 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)</i> K321: K351:	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	COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21 SMALL (16 BEDS OR LESS) K8: 1 PROMPT 2 SLOW 3 IMPRACTICAL K8: 4 PROMPT 5 SLOW 6 IMPRACTICAL K8: 7 PROMPT 8 SLOW 9 IMPRACTICAL K5: ENTER E-SCORE HERE e.g 2.5
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																										

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

A1
 (COMP. WITH ALL PROVISIONS)

A2

X

 (ACCEPTABLE POC)

A3
 (WAIVERS)

A4
 (FSSES)

A5
 (PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC: B.	K180: A. X FULLY SPRINKLERED (All required areas are sprinklered) B. PARTIALLY SPRINKLERED (Not all required areas are sprinklered) C. NONE (No sprinkler system)
---	--

***MANDATORY**

S5254032

MINNESOTA DEPARTMENT OF HEALTH
Health Regulation Division
85 East Seventh Place, Suite 300, P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email for Administrator:	<u>Briana.sturm@benedictineliving.org</u>
Administrator:	<u>BRIANNA STURN Briana Sturm</u>
National Provider Identifier (NPI) Number:	<u>1841620440</u>
One facility may have multiple NPI Numbers. Please verify the NPI number associated with the provider type for this survey, i.e. for a nursing home survey, the NPI Number will be associated with the Nursing Home.	

OWNERSHIP INFORMATION AT THE TIME OF SURVEY

Name of Facility: REGINA SENIOR LIVING City: HASTINGS

Name of Legal Entity Operating Provider: REGINA SENIOR LIVING

Name and Address of Governing Board President:

Name: NICK CONZEMIUS

Address: 124 FARM ST

City/State/Zip: HASTINGS, MN 55033

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

Name of Facility: _____ City: _____

Name of Legal Entity Operating Provider: _____

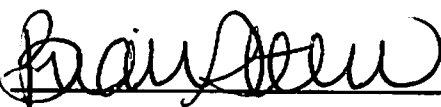
Name and Address of Governing Board President:

Name: _____

Address: _____

City/State/Zip: _____

SIGNATURE

Completed by: 

Title: Executive Director

Date: 7/26/21

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)	☒	☐	☐	

Name of Facility

2012 LIFE SAFETY CODE

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	☒	☐	☐	

Name of Facility

2012 LIFE SAFETY CODE

ID PREFIX	MET	NOT MET	N/A	REMARKS																							
K133	☒	☐	☐	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																							
K161	☒	☐	☐	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 border="1"> <thead> <tr> <th></th> <th>Construction Type</th> <th></th> </tr> </thead> <tbody> <tr> <td>1</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>☒ II (111)</td> <td>One story non-sprinklered Maximum 3 stories sprinklered</td> </tr> <tr> <td>3</td> <td>☐ II (000)</td> <td rowspan="4">Not allowed non-sprinklered Maximum 2 stories sprinklered</td> </tr> <tr> <td>4</td> <td>☐ III (211)</td> </tr> <tr> <td>5</td> <td>☐ IV (2HH)</td> </tr> <tr> <td>6</td> <td>☐ V (111)</td> </tr> <tr> <td>7</td> <td>☐ III (200)</td> <td rowspan="2">Not allowed non-sprinklered Maximum 1 story sprinklered</td> </tr> <tr> <td>8</td> <td>☐ V (000)</td> </tr> </tbody> </table> REGINA SENIOR LIVING is a 1-story building with full basement. It was constructed in 1965 and was determined to be of Type II (111) construction. In 2012, a TCU was added to the building, having a 2-hr fire separation and determined to be Type II (111) construction. Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and resident rooms, that is monitored for automatic fire department notification. The facility has a capacity of 57 beds and had a census of 43 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:		Construction Type		1	☐ I (442), I (332), II (222)	Any number of stories non-sprinklered or sprinklered	2	☒ II (111)	One story non-sprinklered Maximum 3 stories sprinklered	3	☐ II (000)	Not allowed non-sprinklered Maximum 2 stories sprinklered	4	☐ III (211)	5	☐ IV (2HH)	6	☐ V (111)	7	☐ III (200)	Not allowed non-sprinklered Maximum 1 story sprinklered	8	☐ V (000)
	Construction Type																										
1	☐ I (442), I (332), II (222)	Any number of stories non-sprinklered or sprinklered																									
2	☒ II (111)	One story non-sprinklered Maximum 3 stories sprinklered																									
3	☐ II (000)	Not allowed non-sprinklered Maximum 2 stories sprinklered																									
4	☐ III (211)																										
5	☐ IV (2HH)																										
6	☐ V (111)																										
7	☐ III (200)	Not allowed non-sprinklered Maximum 1 story sprinklered																									
8	☐ V (000)																										

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.

Name of Facility

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						
	☐	I (442), I (332), II (222)	Not allowed non-sprinklered Any number of stories sprinklered					
	☐	II (111)	Not allowed non-sprinklered Maximum 3 stories sprinklered					
	☐	II (000)	Not allowed non-sprinklered Maximum 1 story sprinklered					☐
	☐	III (211)						
	☐	IV (2HH)	Not allowed non-sprinklered					☐
	☐	V (111)						
	☐	III (200)	Not allowed non-sprinklered					
	☐	V (000)						
	<i>Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 18.3.5)</i> <i>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.</i>							
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							

Name of Facility

2012 LIFE SAFETY CODE

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	☒	☐	☐	

Name of Facility 2012 LIFE SAFETY CODE

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. 18.2.2.5.1, 18.2.2.2.6, 19.2.2.5.1, 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. 18.2.2.5.2, 19.2.2.5.2, TIA 12-4	☒	☐	☐	

Name of Facility 2012 LIFE SAFETY CODE

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	☒	☐	☐	

Name of Facility

2012 LIFE SAFETY CODE

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	☒	☐	☐	

Name of Facility 2012 LIFE SAFETY CODE

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	☒	☐	☐	

Name of Facility 2012 LIFE SAFETY CODE

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	☒	☐	☐	

Name of Facility 2012 LIFE SAFETY CODE

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	☒	☐	☐	

Name of Facility

2012 LIFE SAFETY CODE

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	☐	☐	☒	
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	☐	☐	☒	

Name of Facility 2012 LIFE SAFETY CODE

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 <i>If all vertical openings are properly enclosed with construction providing at least a 2 hour fire resistance rating, also check this box.</i> ☐	☒	☐	☐	
	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. <i>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.</i> 19.3.2.1, 19.3.5.9			☒	☐	☐																																	
<table><thead><tr><th>Area</th><th>Automatic Sprinkler</th><th>Separation</th><th>N/A</th></tr></thead><tbody><tr><td>a. Boiler and Fuel-Fired Heater Rooms</td><td>☒</td><td>☒</td><td>☐</td></tr><tr><td>b. Laundries (larger than 100 sq. ft.)</td><td>☒</td><td>☒</td><td>☐</td></tr><tr><td>c. Repair, Maintenance, and Paint Shops</td><td>☒</td><td>☒</td><td>☐</td></tr><tr><td>d. Soiled Linen Rooms (exceeding 64 gal.)</td><td>☒</td><td>☒</td><td>☐</td></tr><tr><td>e. Trash Collection Rooms (exceeding 64 gal.)</td><td>☒</td><td>☒</td><td>☐</td></tr><tr><td>f. Combustible Storage Rooms/Spaces (over 50 sq. ft.)</td><td>☒</td><td>☒</td><td>☐</td></tr><tr><td>g. Laboratories (if classified as Severe Hazard - see K322)</td><td>☐</td><td>☐</td><td>☒</td></tr></tbody></table>								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)	☐	☐	☒
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)	☐	☐	☒																																				



Name of Facility2012 LIFE SAFETY CODE

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, <i>Standard on Fire Protection for Laboratories Using Chemicals</i> . 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)	☐	☐	☒	

Name of Facility 2012 LIFE SAFETY CODE

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)	☐	☐	☒	

Name of Facility

2012 LIFE SAFETY CODE

ID PREFIX		MET	NOT MET	N/A	REMARKS
K324	Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, <i>Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations</i> , 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	☐	☒	☐	It was revealed during the walk-through of the facility that in the Physical Therapy / Occupational Therapy Room, the stove control switch, on the wall adjacent to the stove, was a twist-turn switch – having no lock-out capabilities or means to secure Main Kitchen is located in hospital portion of the complex
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	☒	☐	☐	

Name of Facility 2012 LIFE SAFETY CODE

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 B <i>Indicate flame spread rating(s).</i> _____	☒	☐	☐	
	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 <i>Indicate flame spread rating(s).</i> _____	☐	☐	☒	
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, <i>National Electric Code</i> , and NFPA 72, <i>National Fire Alarm Code</i> 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	☒	☐	☐	

Name of Facility 2012 LIFE SAFETY CODE

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	☒	☐	☐	

Name of Facility

2012 LIFE SAFETY CODE

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, <i>National Electric Code</i> , and NFPA 72, <i>National Fire Alarm and Signaling Code</i> . 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	☐	☐	☒	

Name of Facility

2012 LIFE SAFETY CODE

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, <i>Standard for the Installation of Sprinkler Systems</i>. 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, <i>Standard for Installation of Sprinkler Systems</i>. 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, <i>Standard for the Installation of Sprinkler Systems</i>. 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, <i>Standard for Installation of Sprinkler Systems</i>. 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, <i>National Fire Alarm and Signaling Code</i>, 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	☒	☐	☐	

Name of Facility

2012 LIFE SAFETY CODE

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, <i>Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems</i> . Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked. 07/06/2021 b) Who provided system test. VIKING c) Water system supply source. CITY <i>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.</i> 9.7.5, 9.7.7, 9.7.8, and NFPA 25	☐	☒	☐	1) It was revealed during walk-through of the facility that a portion of the ceiling directly above the fire sprinkler system and sprinkler heads in the Physical Therapy Area, located in the basement, was missing. The absence of the amount of finished ceiling viewed, could result in delayed activation of sprinkler heads and sprinkler system in the event of a fire in that area. 2) It was revealed during staff interview that the missing ceiling directly above the fire sprinkler system and sprinkler heads in the Physical Therapy Area, located in the basement, was part of a sprinkler system upgrade. During documentation review no working plans associated to the sprinkler system were presented for review -or- an associated timeline of project completion
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, <i>Standard for Portable Fire Extinguishers</i> . 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	☒	☐	☐	

Name of Facility **2012 LIFE SAFETY CODE**

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. B <i>If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area.</i> 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	☐	☐	☒	

Name of Facility 2012 LIFE SAFETY CODE

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.	☐	☐	☒	

Name of Facility

2012 LIFE SAFETY CODE

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 <i>Detail in REMARKS zone dimensions including length of zones and dead-end corridors.</i> 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 <i>Detail in REMARKS zone dimensions including length of zones and dead-end corridors.</i>	☒	☐	☐	
		☐	☐	☒	

Name of Facility 2012 LIFE SAFETY CODE

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) <i>Describe any mechanical smoke control system in REMARKS.</i>	☒	☐	☐	
	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 <i>Describe any mechanical smoke control system in REMARKS.</i>	☐	☐	☒	
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	☒	☐	☐	

Name of Facility 2012 LIFE SAFETY CODE

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.	☒	☐	☐	

Name of Facility

2012 LIFE SAFETY CODE

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, <i>National Fuel Gas Code</i> , electrical wiring and equipment complies with NFPA 70, <i>National Electric Code</i> . 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	☒	☐	☐	
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	☒	☐	☐	
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	☒	☐	☐	

Name of Facility

2012 LIFE SAFETY CODE

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, <i>Safety Code for Elevators and Escalators</i> . Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, <i>Safety Code for Existing Elevators and Escalators</i> . 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	☒	☐	☐	

Name of Facility 2012 LIFE SAFETY CODE

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, <i>Safety Code for Elevators and Escalators</i>. Firefighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, <i>Safety Code for Elevators and Escalators</i>, 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, <i>Safety Code for Existing Elevators and Escalators</i>. (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	☐	☐	☒	

Name of Facility

2012 LIFE SAFETY CODE

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	☒	☐	☐	
	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.	☒	☐	☐	

2012 LIFE SAFETY CODE

ID PREFIX	Name of Facility	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	☐	☒	☐	It was revealed during documentation review that the Fire Safety Plan was missing informational content associated to notification of the fire department (call 9-1-1), as-well-as plans and routes whereby resident would be relocated or evacuated from the facility (floor-plan with routes and points of egress)
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	☒	☐	☐	

Name of Facility 2012 LIFE SAFETY CODE

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	☒	☐	☐	

Name of Facility

2012 LIFE SAFETY CODE

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 <i>Standard for Fire Doors and Other Opening Protectives</i>. 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)	☒	☐	☐	

Name of Facility

2012 LIFE SAFETY CODE

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. 18.7.7 2012 NEW When installed, engineered smoke control systems are tested in accordance with NFPA 92, <i>Standard for Smoke Control Systems</i> . 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	☒	☐	☐	

Name of Facility

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)	☐	☐	☒	

Name of Facility

2012 LIFE SAFETY CODE

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)	☐	☐	☒	

Name of Facility

2012 LIFE SAFETY CODE

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)	☒	☐	☐	

Name of Facility 2012 LIFE SAFETY CODE

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)	☐	☒	☐	It was revealed during documentation review the records provided for review were generic in information content, not providing detailed information associated to the duplex and/or quad outlets located in resident rooms
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	☒	☐	☐	

Name of Facility

2012 LIFE SAFETY CODE

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)	☒	☐	☐	

Name of Facility 2012 LIFE SAFETY CODE

ID PREFIX		MET	NOT MET	N/A	REMARKS
K919	Electrical Equipment – Other List in the REMARKS section any NFPA 99 Chapter 10, <i>Electrical Equipment</i> , 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) assemblies 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	☒	☐	☐	

Name of Facility 2012 LIFE SAFETY CODE

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)	☒	☐	☐	

Name of Facility 2012 LIFE SAFETY CODE

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)	☐	☒	☐	It was revealed that the Med Gas Storage Room had mixed storage of cylinders and there was no in-room signage to identify placement location for 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)	☒	☐	☐	

Name of Facility 2012 LIFE SAFETY CODE

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 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, <i>Transfilling of High Pressure Gaseous Oxygen Used for Respiration</i> . 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)	☒	☐	☐	

Name of Facility

2012 LIFE SAFETY CODE

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)	☒	☐	☐	
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)	☒	☐	☐	

Name of Facility

2012 LIFE SAFETY CODE

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: ○ application site is dry prior to draping and use of surgical equipment. ○ pooling of solution has not occurred or has been corrected. ○ solution-soaked materials have been removed from the OR prior to draping and use of surgical devices. ○ 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 (<i>Signature</i>)	Title	Office	Date
Fire Authority Official (<i>Signature</i>)	Title	Office	Date

Provider Number	Facility Name	Survey Date
K1		*K4

K6	DATE OF PLAN APPROVAL	K3	MULTIPLE CONSTRUCTION	☐	A. BUILDING
			TOTAL NUMBER OF BUILDINGS _____		B. WING
			NUMBER OF THIS BUILDING _____		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		
<i>(Check if K321 or K351 are marked as not applicable in the 2786 M, R, T, U, V, W, X, and Y.)</i> K321: <input style="width: 40px; height: 30px;" type="checkbox"/> K351: <input style="width: 40px; height: 30px;" type="checkbox"/>		

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	
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)	(FSSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC		K0180	
B. ☐		A. ☐ FULLY SPRINKLERED (All required areas are sprinklered)	B. ☐ PARTIALLY SPRINKLERED (Not all required areas are sprinklered)
			C. ☐ NONE (No sprinkler system)

Form CMS-2786R (07/2018)



CMS Inspection Report

Inspection Information

Inspection Date: 7/28/2021

Inspection Type: Cert - Scheduled

Inspection No: 004149

Facility Information

Regina Senior Living
1175 Nininger Road Hastings, MN 55033
Email: megan.diamond@benedictineliving.org

***Property Use:** HC - Nursing Home - 24-hour care
Nursing homes, 4 or more persons

Occupant Loads

Description / Loads

Licensed Bed Count : 57

Primary Contact

Diamond, Megan (Administrator) Work Phone: 952-233-4408 | Email: megan.diamond@benedictineliving.org
Jurrens, Steve (State Inspector) Email/Cell: steven.jurrens@state.mn.us (651) 470-4416

Violations

On the above date, an inspection was conducted for the purposes of fire and life safety. The following conditions were observed that do not meet the minimum requirements of the Minnesota State Fire Code. Failure to correct identified fire and life safety deficiencies in a timely manner is a criminal violation pursuant to Minn. Stat. § 299F.011, subd. 6. There is a variance procedure available. Please contact the inspector named for further assistance.

Code - Description	Days to Correct	Violation Status
** Hospital/Nursing Home - K324 : Cooking Facilities - Violation Location: - Comments: Based on observation and staff interview, the facility failed to maintain proper safety and security related to a cooking device in a resident accessible corridor in accordance with the Life Safety Code NFPA 101, 2012 edition, section 19.3.2.5.3. This deficient condition could have an isolated impact on the residents within the facility. Findings Include: On 07/28/2021 between 09:00 AM to 02:00 PM, it was revealed during the walk-through of the facility that in the Physical Therapy / Occupational Therapy Room, the stove control switch, on the wall adjacent to the stove, was a twist-turn switch – having no lock-out capabilities or means to secure This deficient practice was confirmed by the Facility Administrator at the time of discovery. ---	60	Violation Noted - Schedule Recheck

** Hospital/Nursing Home - K353 : Sprinkler System-Maintenance And Testing	60	Violation Noted - Schedule Recheck
- Violation Location:		
- Comments: Based on observation, staff interview and documentation review, 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 5.2.1.1, 5.2.1.1.3, 5.2.1.2. NFPA13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 8.1.1, 8.5.4.1, 22.1 This deficient condition could have an isolated impact on the residents within the facility.		

Findings include:

1. On 07/28/2021 between 09:00 AM to 02:00 PM, it was revealed during walk-through of the facility that a portion of the ceiling directly above the fire sprinkler system and sprinkler heads in the Physical Therapy Area, located in the basement, was missing. The absence of the amount of finished ceiling viewed, could result in delayed activation of sprinkler heads and sprinkler system in the event of a fire in that area.
2. On 07/28/2021 between 09:00 AM to 02:00 PM, it was revealed during staff interview that the missing ceiling directly above the fire sprinkler system and sprinkler heads in the Physical Therapy Area, located in the basement, was part of a sprinkler system upgrade. During documentation review no working plans associated to the sprinkler system were presented for review -or- an associated timeline of project completion

This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.

** Hospital/Nursing Home - K711 : Evacuation And Relocation Plan	60	Violation Noted - Schedule Recheck
- Violation Location:		
- Comments: Based on document review and staff interview, the facility failed to properly document the evacuation and relocation plan in accordance with the Life Safety Code NFPA 101, 2012 edition, sections 19.7.2, 19.7.2.1.2, 19.7.2, 19.7.2.2. This deficient condition could have a widespread impact on the residents within the facility.		

Findings include:

On 07/28/2021 between 09:00 AM to 02:00 PM, it was revealed during documentation review that the Fire Safety Plan was missing informational content associated to notification of the fire department (call 9-1-1), as-well-as plans and routes whereby resident would be relocated or evacuated from the facility (floor-plan with routes and points of egress)

This deficient condition was confirmed by the Maintenance Director at the time of discovery.

** Hospital/Nursing Home - K914 : Electrical Systems-Maintenance And Testing	60	Violation Noted - Schedule Recheck
- Violation Location:		
- Comments: Based on document review and staff interview, the facility failed to properly document the annual electrical receptacle testing in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.3.3.2, 6.3.4.1 and 6.3.4.2. This deficient condition could have a widespread impact on the residents within the facility.		

Findings include:

On 07/28/2021 between 09:00 AM to 02:00 PM, it was revealed during documentation review the records provided for review were generic in information content, not providing detailed information associated to the duplex and/or quad outlets located in resident rooms

This deficient practice was confirmed by the Maintenance Director at the time of discovery.

** Hospital/Nursing Home - K923 : Gas Quipment-Cylinder And Container Storage - Violation Location: - Comments: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.4, 11.6.5 This deficient condition could have an widespread impact on the residents within the facility.	60	Violation Noted - Schedule Recheck
Findings include:		
On 07/28/2021 between 09:00 AM to 02:00 PM, it was revealed that the Med Gas Storage Room had mixed storage of cylinders and there was no in-room signage to identify placement location for empty / full cylinders		
This deficient practice was confirmed by the Maintenance Director at the time of discovery.		

Inspection Notes

Notes: An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/28/2021. At the time of this survey, REGINA SENIOR LIVING 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.

REGINA SENIOR LIVING is a 1-story building with full basement. It was constructed in 1965 and was determined to be of Type II (111) construction. In 1965, a TCU was added to the building, having a 2-hr fire separation and determined to be Type II (111) construction.

Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

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

The facility has a capacity of 57 beds and had a census of 43 at the time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:

End of Report

Printed: 08/20/2021 19:59

Original
MN State Fire Marshal Division

RMK 3/7/2019
SRJ 07/28/2021

