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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HCXQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00061

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245573**
2.STATE VENDOR OR MEDICAID NO.
(L2) **454040900**

3. NAME AND ADDRESS OF FACILITY
(L3) **CLARA CITY CARE CENTER**
(L4) **1012 NORTH DIVISION STREET PO BOX 797**
(L5) **CLARA CITY, MN** (L6) **56222**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/23/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **48** (L18)
13.Total Certified Beds **48** (L17)

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	48			
(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 Date :
Lois Boerboom, HFE NE II 11/08/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/22/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00131
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered

October 21, 2021

Administrator
Clara City Care Center
1012 North Division Street PO Box 797
Clara City, MN 56222

RE: CCN: 245573
Cycle Start Date: September 23, 2021

Dear Administrator:

On September 23, 2021, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 5, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 5, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 5, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction.

The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 5, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Clara City Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 5, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 23, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you

have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245573	A. BUILDING _____ B. WING _____	C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA CITY CARE CENTER	**1012 NORTH DIVISION STREET PO BOX 797 CLARA CITY, MN 56222**

(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 9/20/21 through 9/23/21, 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. 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.	E 000		
F 000	INITIAL COMMENTS On 9/20/21 through 9/23/21, 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 SUBSTANTIATED: H5573032C (MN57716), however NO deficiencies were cited due to actions implemented by the facility prior to survey. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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	F 000		

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

Electronically Signed | 10/29/2021

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

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F 000	Continued From page 1 regulations has been attained.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have a policy or procedure to report and investigate the elopment of 1 of 1 resident (R19) to the State Agency for potential neglect. Findings include: R19's 7/23/21, quarterly Minimum Data Set (MDS) identified a diagnosis of Alzheimer's dementia. R19 required extensive assist of 2 staff for bed mobility, transfers, walking, dressing, and toileting and supervision of 1 staff for eating. R19's 9/12/21, nurse's notes identified R19 had eloped from the facility. Staff were not able immediately able to locate R19, so they began a search. Staff looked outside on the patio, outside the front of the building, and out by the road in front of the facility. R19 was not found until about	F 607	This Plan of Correction constitutes written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law. Clara City Care Center's Elopement policy was reviewed and updated on 9/29/21 to include reporting requirements to the State Agency for potential neglect and investigative procedures to ensure incidents of elopement are properly investigated. Resident 19's elopement risk assessment was completed 10/28/21.	11/12/21

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F 607	Continued From page 2 5 minutes later when R19 walked back into the building through the front door unattended. Review of R19's care plan dated 7/29/21 identified R19 was at risk for elopement and had an intervention of a WanderGuard. There was no mention where on R19's person, the WanderGuard was to be placed. On 9/13/21, the care plan was updated to identify the WanderGuard was to be on R19's ankle. Interview on 9/23/21 at 9:45 a.m., with registered nurse (RN)-B revealed the interdisciplinary team (IDT) had reviewed R19's elopement on 9/13/21. The IDT however, did not classify it as an elopement. RN-B explained the team did not believe R19 had gotten off the property as he came back so quickly, so no report to the State Agency had been filed. Interview on 9/23/21 a.m., with administrator identified he had been made aware R19 had eloped from the building on 9/12/21. He had been in contact with the the social services designee (SSD) and the director of nursing (DON) after the event to review the situation. The administrator was unable to verify if the resident had remained on the property during the time staff were not able to locate R19 in the facility. The administrator reported staff did not believe R19 had gotten off the property. The administrator agreed he was unaware why staff who had been looking for R19 were not able to see him in the front of the building while they were searching for him. The elopement had not been reported to the State Agency. The administrator concluded the only intervention completed was staff moved R19's WanderGuard bracelet to his ankle. There had been no further investigation of the event.	F 607	All resident have the potential to be affected by this deficient practice. All residents will have an elopement risk assessment completed by 11/11/21 and all new admissions will have an elopement risk assessment completed on admission. All staff will receive training on elopement policy and reporting on 11/2/21. DON or designee will audit resident records of all residents at risk for elopement to ensure proper documentation and reporting to state agency occurred if an elopement event occurred monthly x 6 months and report to QAPI Committee for review and further action.	

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F 607	Continued From page 3 Review of undated, Missing Resident policy revealed if a resident not able to be located and is not on a planned absence from the facility, the event was to be considered as a "missing resident". Staff were to begin looking for the missing resident as soon as the situation was identified. The policy failed to indicate when a report should be filed with the State Agency following a missing resident event to identify the cause and/or potential negelect.	F 607		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow physician's orders for 1 of 1 resident (R29) with specific wound care dressing treatment. Findings include: R29's 8/20/21, Significant Change Minimum Data Set (MDS) assessment identified R29 had intact cognition, and required supervision with activities of daily living (ADLs). R29 had diagnosis of one Stage 2 pressure ulcer on his right shoulder. R29's current, undated care plan identified he had a right acromioclavicular joint (AC) (collar bone separates from the shoulder blade) following a fall prior to his admission the facility. R29 was at risk	F 658	Resident 29's wound was healed 9/23/21. DON or designee will audit physician orders for all current residents with wound dressing treatments to ensure physician orders are being properly followed. Wound care dressing policy updated to address following physician orders and proper procedure to follow in order to request a change to the physician order, and the need to follow the current order until a new order is properly implemented. Nursing staff will be inserviced on proper wound dressing changes and the need to ensure they follow the documented	11/12/21

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F 658	Continued From page 4 for skin breakdown as a result of the injury, and the MDS identified the presence of a Stage 2 pressure ulcer on the bony prominence of his right shoulder. R29's physician orders identified on 8/3/21, facility staff identified on 8/3/21, the wound nurse consultant recommended a Cutimed Sorbact (antibacterial wound dressing) to be used. R29's physician (MD)-B agreed and signed the order that same day. Interview on 9/20/21 at 2:50 p.m., with R29 identified he had a "sore" on his right shoulder that had occurred following a fall with a fracture that required surgical repair. R29 identified the fall occurred in the assisted living before he came to the facility. R29 stated the "bone had grown" following the surgery and caused the problem. He moved his shirt aside to show a dressing on the end of his right clavicle covering a raised area. R29 identified nursing staff changed the dressing daily, but he was not aware if the wound was open or if there was any drainage. Observation and interview on 9/22/21 at 8:55 a.m. with licensed practical nurse (LPN)-B, as she changed the dressing located on R29's right shoulder. LPN-B described the area as reddened with some slight peeling of the top layer of skin, but no open areas or drainage. LPN-B changed the dressing wearing appropriate personal protective equipment (PPE), cleansed the area with a saline pad, and cut a small piece of hydrogel absorbent sheet to fit the raised, reddened area and applied a cushion border dressing. LPN-B identified the wound nurse had utilized hydrogel absorbent sheet on R29's wound the week previously instead of the physician	F 658	physician order on 11/2/21. DON or designee will audit medical records of residents with wound requiring wound dressing treatments to ensure physician orders are followed and observe actual wound care dressing changes by licensed nurses weekly x until compliance is reached, monthly x6 months to ensure compliance is maintained and report all findings to QAPI committee to determine compliance or need to continue audits.	

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F 658	Continued From page 5 ordered Cutimed Sorbact dressing listed on the current signed provider orders and she was not aware of a change in orders, but had used the Hydrogel absorbent sheet instead of the Cutimed Sorbact dressing as the wound nurse had done. R29's progress notes identified on 8/20/21, R29's wound dressing was changed to a hydrogel dressing. On 8/21/21, staff documented they used a Mepilex and an alginate (wound debriding) dressing. On 8/29/21, staff switched back to the Cutimed dressing. There was no documentation in the progress notes to identify why staff had switched out R29's dressing types, nor was there any indication the provider was notified. Interview and document review on 9/22/21 at 1:24 p.m. with registered nurse (RN)-B identified the hydrogel dressing used on R29's shoulder wound was not the ordered dressing identified on the electronic physician's order sheet. The error was not identified until pointed out during the interview with review of the signed provider order. RN-B identified she would need to "look into the issue" to identify if there was a physician' order that had been hand written rather than entered into the electronic system. Further interview on 9/23/21 at 9:26 a.m., with RN-B identified the dressing being utilized for shoulder wound was not the ordered dressing due to receipt of the incorrect product. RN-B noted it "should have been caught". Interview on 9/23/21 at 1:33 p.m., with the RN infection preventionist (IP) identified R29's ordered dressing was indicated for a wound with infected properties and had been changed from the Cutimed Sorbact dressing to the Hydrogel absorbent sheet without obtaining an order from the provider. The IP identified she would have	F 658		

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F 658	Continued From page 6 expected the provider to be notified of the request to change treatment, and the order documented in the medical record if there was a change in treatment. A policy for dressing changes and implementation of provider orders was requested but not provided by the end of the survey.	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a portable oxygen tank (E-cylinder) was safely secured for 1 of 1 resident (R234) after admission to the facility. Finding include: Observation and interview on 9/20/21 at 2:39 p.m., with R234 identified she was alert and oriented to surroundings and had been admitted from an acute care facility following an exacerbation (an acute increase in the severity of a problem), of COPD and CHF. R234 was observed seated in a recliner with oxygen in place through a long extension tubing connected to an oxygen concentrator. A portable E-cylinder with the regulator attached was leaning unsecured in	F 689	On 9/22/21 the empty oxygen cylinder from room 105 was secured in the oxygen room in the area designated for empty cylinders. All residents have the potential to be affected by this deficient practice. Maintenance director, DON and administrator have updated the oxygen policy/procedure to ensure staff will secure oxygen cylinders appropriately. All staff meeting will be held 11/2/21 to review updated oxygen policy/procedure and ensure staff understand proper place and way to secure oxygen cylinders.	11/12/21

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F 689	Continued From page 7 the corner of the room between the dresser and the window. R234 identified she had been using the tank itermittently since she was admitted to the facility. Upon inspection, the E- cylinder was empty. R234 was admitted to the facility in September 2021with diagnoses of acute and chronic respiratory failure with hypoxia, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD). R234's initial, 48-hour care plan identified she required continuous oxygen (O2) at 2.5 - 3 Liters per minute L/min and utilized a nasal cannula. R234's 9/14/21, physician's orders identified R234 was to have O2 at 3-5 L/min to keep her oxygen saturation (O2 SATs) at 90-94%. Observation on 9/20/21 at 6:00 p.m., R234 was eating supper meal in her room with O2 on via cannula attached to concentrator. The E-cylinder oxygen tank was noted to be in the same location, and remained unsecured. Observation on 9/21/21 at 8:30 a.m., of R234's room identified the E-cylinder oxygen tank remained propped in corner of the room, unsecured. Observation on 9/21/21 at 1:00 p.m. of R234's room identified the E-cylinder oxygen tank remained in the same location in the corner of the room. The oxygen tank was not removed from R234's room until identified as a safety hazard by the fire marshall between 1:30 p.m. and 2:00 p.m. Interview on 9/22/21 at 9:09 a.m., with nursing	F 689	DON or designee will audit by checking each occupied room in the facility to ensure any oxygen cylinders present are properly secured 2x week for 2 weeks, then weekly for 2 weeks and then monthly x 4 months and report findings to QAPI committee to determine compliance or need to continue monitoring.	

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F 689	Continued From page 8 assistant (NA)-B identified R234 utilized continuous O2 at 3 L/min, and when she was up and about utilized the portable oxygen unit located on her walker. NA-B identified the E-cylinder tank sitting unsecured in the corner between the dresser and the window was R234's personal oxygen tank she brought with, and it had been present since admission. Interview on 9/22/21 at 1:31 p.m., with the facility administration identified the oxygen tank E-cylinderhad not been properly secured and should not have been left in R234's room following admission. The administrator's expectation was the tank should have been removed from R234's room and stored in the oxygen storage area in the appropriate secured holder. A policy on portable oxygen use and storage was requested, but not provided by the end of the survey.	F 689		
F 811 SS=D	Feeding Asst/Training/Supervision/Resident CFR(s): 483.60(h)(1)-(3) §483.60(h) Paid feeding assistants- §483.60(h)(1) State approved training course. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if- (i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and (ii) The use of feeding assistants is consistent with State law. §483.60(h)(2) Supervision. (i) A feeding assistant must work under the	F 811		11/12/21

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F 811	Continued From page 9 supervision of a registered nurse (RN) or licensed practical nurse (LPN). (ii) In an emergency, a feeding assistant must call a supervisory nurse for help. §483.60(h)(3) Resident selection criteria. (i) A facility must ensure that a feeding assistant provides dining assistance only for residents who have no complicated feeding problems. (ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. (iii) The facility must base resident selection on the interdisciplinary team's assessment and the resident's latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 paid feeding assistant (PFA)-A was prohibited from feeding 3 of 3 residents (R8, R16, and R21) with complicated feeding problems requiring a mechanically-altered diet. The facility also failed to ensure the PFA was supervised at all times by a nurse while performing feeding assistance at all times. Observation on 9/21/21 at 7:26 a.m., of R21 identified she was being assisted to eat her meal by PFA-A. R21 had pureed foods on her plate at the time of the observation. Further observation on 9/21/21 at 8:10 a.m., identified R8 was in the dining room being fed by a nursing assistant (NA)-A. When another (unidentified) resident had completed their meal, NA-A took that resident back to the dayroom.	F 811	Residents 8, 16, and 21 are being assisted with eating only by trained personnel who have the training necessary to provide that service in their scope of practice. Clara City Care Center has determined they will no longer be utilizing the Paid Feeding Assistant position. All staff will receive verbal notice of decision not to utilize this program during all staff in-service on 11/2/21. DON or designee will audit personnel files of those providing assistance with feeding any resident who requires that service to ensure they are properly trained to be able to provide that assistance. These audits will be completed monthly x 6 months with	

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F 811	Continued From page 10 PFA-A took over feeding R8. PFA-A continued feeding R8, alternating food and fluids as R8 accepted. At 8:24 a.m., NA-A was heard asking NA-B if she would be staying in the dining room, while she needed to take anther resident back to their room and said "Someone from the nursing department needs to be in the dining room while [PFA-A] was feeding [R8]." At 9:00 a.m., PFA-A discontinued to feed R8 while it was determined that R8 was no longer accepting food or sips of fluids. R21's 11/18/20, quarterly, Minimum Data Set (MDS), identified R21 was severely cognitively impaired, required extensive assistance with Activities of Daily Living (ADL), and total assistance of 1 staff to eat her meals. R21 had a diagnosis of Alzheimer's dementia. R21's 2/17/21, Care Area Assessment (CAA) for Nutritional Status identified R8 required a mechanically altered diet" related to her Alzheimer's dementia disease. R21's current, undated, care plan identified staff were to provide assistance with meals. There was no mention use of a PFA for meals was appropriate due to R21's swallowing disorder. R21's 11/18/20, physician orders identified R21 required staff to ensure R21 had a regular, pureed diet with honey thickened liquids. R21's 7/21/21, nutrition assessment identified R21 was receiving a National Dysphagia Diet level 1 (NDDI) diet (a diet used for residents with swallowing difficulties who are at risk for aspiration of food and liquid into their lungs). R16's 7/19/21, Significant Change MDS identifies	F 811	findings reported to QAPI Committee for review and further action.	

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F 811	Continued From page 11	F 811		

R16 requires complete assistance of 2 staff for bed mobility, transfers, and toileting, complete assist of 1 staff for dressing and eating. R16 has a diagnosis of Alzheimer's dementia and was identified as requiring a full liquid diet.

R8's 6/21/21, annual MDS identified R8 was severely cognitively impaired, required extensive assistance of two with activities of daily living, and extensive assistance of one to eat her meals. In review of R8's Care Area Assessment (CAA) for Nutritional Status indicated a need for special diet or altered consistency.

R8's 6/23/21, physician orders indicated R8 required a diet change of NDD3 (dysphagia advanced diet), which included soft foods that require more chewing ability.

R8's current, undated care plan identified on 7/25/19, a Nutritional Status intervention was documented as "Resident will be seated at the Feed Assist table for assistance and cueing during meals." The care plan did not specifically indicate those residents at the "Feed Assist table" were able to be fed by a PFA.

Interview on 9/22/21 at 7:55 a.m., with PFA-A identified she was aware R8, R16, and R21 had swallowing issues. She was unaware residents with swallowing problems were not appropriate for a PFA to assist to feed.

Further observation and interview on 9/22/21 8:10 a.m. to 9:05 a.m., identified there were no licensed nursing staff (a registered nurse (RN) or a licensed practical nurse (LPN)) in the dining room to provide supervision of PFA-A. PFA-A identified R8 was 1 of the 3 residents with

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F 811	Continued From page 12 swallowing concerns with special diets she fed when scheduled as a PFA-A. She indicated there was to be a nursing staff member, not necessarily a nurse, in the dining room when she was feeding a resident. She pointed to the NA who was located in the dining room as being sufficient at providing supervision while she fed residents. Observation on 9/22/21 from 7:26 a.m. through 8:00 a.m., in the East dining room identified there was no nursing staff immediately available in the dining room for supervision and in case of an emergency. Review of the 5/22/20, Resident Feed Attendant Waiver During COVID Crisis Policy and Procedure identified a resident feed attendant (PFA) was to work under the supervision of an RN or LPN. A PFA was not to be assigned to feed any resident who would be at risk for choking while eating or drinking, or present other risk factors that may require emergency intervention. The PFA was to have a walkie and was to be instructed to use that in an emergency or call for help if needed. The policy made no mention a PFA was only to feed residents who have no complicated feeding problems such as difficulty swallowing. There no mention nurses or nurse aides must continue to assist residents who require the assistance of staff who have more specialized training in order to eat or drink. The policy also failed to direct RN's or LPN's to be located close enough to the resident that he or she could promptly respond in an emergency.	F 811		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment.	F 838		11/12/21

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F 838	Continued From page 13 The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical);	F 838		

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F 838	Continued From page 14 (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the facility assessment was completed annually and/or as needed to include the resident census, specific care required for each resident, the amount and number of equipment required, all facility personnel including managerial staff, and an updated risk assessment including emerging infectious diseases. This had the potential to affect all 36 residents residing in the facility. Findings include: Review of the facility assessment identified the last review date 10/3/18. There was no mention of specific resident or facility information required. The assessment lacked documentation of resident census, specific care required for each	F 838	Clara City Care Center's facility assessment was completed 9/27/21 to include resident census, specific care required for each resident, the amount and number of equipment required, all facility personnel including managerial staff and an update risk assessment including emerging infectious diseases. All Residents have the potential to be affected by this deficient practice. All staff will be in-serviced on the components of the Facility Assessment and the need to review annually and as resident needs or characteristics change on 11/2/21.	

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F 838	Continued From page 15 resident, the amount and number of equipment required, all facility personnel including managerial staff, and an updated risk assessment including emerging infectious diseases. Interview on 9/23/21 at 4:44 p.m., with the facility administrator identified he agreed, the facility assessment had not been updated since 2018. The administrator identified he had began his employment in 2019, and was aware of the requirement for review the Facility Assessment annually and as needed. He had not ensured completion had occurred as required and contained the necessary components. Review of the 8/5/21 Clara City Care Center: QAPI Plan identified the Facility Assessment was to be completed on an annual basis and as needed to include overview of the care and services provided.	F 838	Facility Assessment will be added to the monthly QAPI agenda in November 2021 and moving forward in order to monitor the changes in resident census, services we provide, competencies needed, and etc to prompt a review/update of the Facility Assessment.	
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to	F 868		11/12/21

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F 868	Continued From page 16 identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed document the absence or presence of 1 of 1 medical director (MD) required to be in attendance quarterly at Quality Assurance Performance Improvement (QAPI) meetings. Findings include: Review of the quarterly QAPI meeting minutes and agenda identified in October 2020, January 2021, April 2021, and July 2021, the MD was not documented as having attended. Review of the 8/5/21, QAPI Plan identified the QAPI committee members required to be present consisted of the administrator, the director of nursing (DON), the consultant pharmacist, the MD, the infection preventionist (IP), and department managers. Interview on 9/23/21 at 3:30 p.m. with the facility administrator identified the facility failed to document the absence or presence of required persons in attendance at the QAPI meetings.	F 868	Clara City Care Center's QAPI Committee met 9/30/21 and 10/12/21 with a proper sign in sheet maintained to document presence or absence of Medical Director required to be in attendance quarterly at QAPI committee meetings, Medical director was present for the 10/12/21 meeting. All staff including QAPI Committee members received training on QAPI requirements, including necessary attendance and documentation of attendance on 11/2/21. DON or designee will audit QAPI minutes and associated documents to ensure proper documentation of attendance monthly x 8 months and report findings to QAPI Committee monthly for review and further action.	
F 880 SS=F	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	F 880		11/12/21

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F 880	Continued From page 17 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention 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	F 880		

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	245573	A. BUILDING _____ B. WING _____	C 09/23/2021

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F 880	Continued From page 18 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 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, interview and record review the facility failed to implement an appropriate infection control program to include data analysis of resident infections, tracking and trending to the risk of spread of infections to other residents in the facility in accordance with Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guideline for COVID-19. Furthermore, the facility failed to ensure 1 of 1 resident (R1), with known Methicillin-Resistant Staphylococcus Aureus (MRSA) (bacterial infection resistant to most antibiotics) infection had their linens appropriately contained and laundered, had appropriate signage and PPE outside R1's door, and performed appropriate infection control technique during 1 of 1 dressing change for R1 to prevent cross-contamination. This had the potential to	F 880	Root Cause Analysis completed 10/28/21 by team including the Administrator, DON, Infection Preventionist and HR manager. Using the RCA to guide our work here is our Plan of Correction. 1. Cohorting Residents/Transmission Based Precautions Isolation Facility immediately upon identification of R1 had moved PPE to the outside of the resident□s room. Contact precautions were initiated based on organism present. Precaution duration will be determined when wound is resolved. Precaution signage is placed on the resident□s door to alert staff and visitors that resident is on transmission precautions.	

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F 880	Continued From page 19 affect all 36 residents who resided in the facility. Findings include: SURVEILLANCE Review of the facility infection control surveillance documentation identified there was no infection control logs for resident and/or staff infections for tracking, trending and surveillance from January 2021 through September 22, 2021. The facility did have a report form for resident illnesses, entitled: Resident Illness Report, however, the facility was only able to provide evidence of the form being filled out for May 2021. In a review of the facility form, entitled: Staff Illness Report, the facility was only able to provide one report dated May 2020. During interview on 9/23/21, at 2:20 p.m. the facility's infection preventionist (IP) stated she had only been in the position of IP for about 2 weeks and had received her certification in infection control on 9/13/21. The IP stated she had only 5 day of training with the previous IP before that IP left the facility. The IP stated the facility was documenting resident infections in each individual resident records and was not collecting data in real-time to track, trend monitor, and prevent the spread of infections throughout the facility. Review of the 7/8/21, Infection Prevention and Control Program Policy identified facility-wide surveillance was to be be performed to identify opportunities to prevent and/ or reduce the rate of infection in residents, employees and visitors. Standard definitions of infection for surveillance in long-term care facilities were to be utilized. Data	F 880	Other Residents: The facility reviewed all residents to determine who would be on precautions, based on findings, would implement as indicated. One other resident was identified with a MDRO and is on contact precautions. All procedures are implemented. Corrective Action: Clara City Care Center Policies on isolation precautions has been reviewed on 10/26/21. Staff will be educated regarding infection prevention practices listed below by 11/2/21. " Transmission-based precautions definitions what they mean in the real world " PPE use " Procedures to prevent cross contamination when providing care and changing dressings Facility Monitoring: Practices will be audited by Infection Preventionist (IP) Monthly to ensure compliance. All results will be reported to the Infection Prevention Committee and then to QAPI for review and further action. 2. Equipment/environment Resident affected: Yellow laundry bin was and is currently in resident s room for all laundry to be placed in laundry for R1. All laundry from yellow bin will be placed in yellow bags and carried to laundry room where they are placed in specific bin to await processing, yellow bagged laundry should	

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F 880	Continued From page 20 was to be collected by chart review, review of microbiological reports, reports from resident care providers and review of other documents as appropriate. Staff were to also to review employee health records and trend data for comparison and reported to the infection prevention committee no less than quarterly. The effectiveness of the infection control program was to be reviewed no less than annually with findings reported to QAPI. There was no mention who or how often data was to be collected, nor that it needed to occur in real-time and measurable for analysis in tracking and trending, critical to prevent potential infection, such as COVID-19. LAUNDRY R1's Face Sheet indicated and entry on 9/2/21, that R1 had the diagnosis of MRSA infection in an open wound. Observation on 9/22/21 at 11:15 a.m. of R1's room identified there was no isolation laundry bin for R1's clothing or linens to be placed into while R1 was in isolation. During tour of the facility's laundry on 9/23/21, at 9:46 a.m. the house keeping and laundry director (HLD) stated she was unaware of any of any infection control / isolation cases currently in the resident population. HLD stated house keeping and laundry would be be informed through the interdisciplinary team meetings that are held daily through the week. HLD stated she was unaware of R1's MRSA infection. HLD stated that if she would have known, there would have been yellow isolation bags place in R1's room, so laundry would of been made aware how to handle R1's laundry.	F 880	never be put down the laundry chute. Laundry is aware of proper contaminated laundry processing. Other Residents: The facility reviewed all residents to determine who would be on precautions, based on findings, would implement as indicated. One other resident was identified to be on precautions, all procedures are in place and being used. Corrective Action: Clara City Care Center has reviewed infection control policies on laundering contaminated clothing. All department leaders will be notified of the need for isolation precautions at daily IDT. Facility Monitoring: Observation audits will be conducted Monthly by IP/designee to ensure compliance. Results will be reported to QAPI Committee for review and further action. 3. Personal Protective Equipment (PPE) Clara City Care Center Policies on PPE was reviewed. Reviewed the proper technique of donning and doffing PPE when appropriate during dressing change and all personal cares with the nurse involved with R1. The facility reviewed all residents to determine who require wound care or use of proper PPE during personal cares and dressing changes and educated all	

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F 880	Continued From page 21 In an interview on 9/23/21, at 1:59 p.m. IP stated they did not feel the need to place isolation precautions on R1 while it was felt that R1's MRSA infection was contained by the dressing and felt there was no reason to contain or separate R1's laundry or launder separately from other residents to eliminate potential cross-contamination. Review of the 7/8/21, Infection Prevention and Control Program Policy identified transmission-based precautions were to be utilized in addition to standard precautions, when the route of transmission was not completely interrupted using standard precautions alone. The policy identified MRSA was a bacteria resistant to treatment with traditional antibiotics. There was no mention of how highly infectious or antibiotic resistant organisms with potential for contamination were to be laundered to prevent cross-contamination. DRESSING CHANGE / PPE R1's 8/30/21, Minimum Data Set (MDS) identified R1 had diagnoses of Parkinson's disease and diabetes and requires extensive assistance of 2 staff for bed mobility, transfers, and toileting. R1 required extensive assist of 1 staff for dressing and personal hygiene. Skin conditions identified on the MDS were one Stage 4 pressure ulcer, one unstageable pressure ulcer, and one venous/arterial ulcer. Observation and interview on 9/22/21 at 10:52 a.m., of licensed practical nurse (LPN)- A identified she was performing dressing changes	F 880	licensed nurses on the proper technique of donning and doffing PPE when appropriate during dressing change and all personal cares Facility Monitoring: Practices will be audited by the Infection Preventionist (IP) on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Audits will continue until 100 % compliance is met. Infection Preventionist or designee will continue to audit at least monthly and results will be reported to QAPI Committee for review and further action. 4. Tracking and Trending Infection Control Program Clara City Care Center Policies on Infection Control and tracking was reviewed. IP has made spread sheets that are at each nurse□s station to help track resident infections. 24-hour report is reviewed daily and information is now put in an excel to be tracked. Staff call in sheets will continue to be used, IP will monitor and record that information to ensure surveillance documentation. All residents and staff could be affected by this deficient practice. All infections going forward for 10/01/21 will be reviewed and recorded by IP and management. DON or designee will audit medical records of residents diagnosed with an infection monthly and ensure proper	

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F 880	Continued From page 22 to R1's left calf area, left heel, right heel, and right foot between the great toe and the third toe where the second toe had recently been amputated. LPN-A began by setting up her dressing supplies on an over-bed table by the side of R1's bed, first putting down a clean barrier between the table and the dressing supplies. LPN-A dropped a roll of unopened Kerlex onto the floor. She then picked it up and placed it on the clean barrier with the other dressing supplies. LPN-A donned a pair of gloves and picked up the 1 pair of scissors she had on her table to remove the soiled dressing over the left calf wound. LPN-A reported that wound had a culture taken which was positive for MRSA. LPN-A removed the soiled dressings. After removing the soiled dressing she discarded it in the bio-hazardous container that was beside the R1's closet door. LPN-A proceeded to use the same contaminated scissors to remove old dressings on 3 other sites on R1 and also cut and place new dressings on each wound, cross-contaminating R1's wounds with the scissors she used on the 1st dressing change that was positive for MRSA. LPN-A was unaware she cross-contaminated wounds by not going from a non-infected wound to a cleaner wound and using the same pair of scissors without disinfection. Interview on 9/23/21 at 1:33 p.m. with the IP identified LPN-A should have: 1) Began with the cleanest wound and moved to the infected wound last. 2) Used a new supplies/scissors for each wound as not to allow for cross-contamination. The PPE station that was set up currently inside R1's bathroom should not be hanging inside the room as staff are to donn appropriate PPE prior to entering the room of a resident on precautions.	F 880	documentation, tracking and trending of infections on excel spreadsheets completed by IP monthly and report findings to QAPI Committee to determine compliance or need for further action.	

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F 880	Continued From page 23 She also verified the door should have had signage indicating R1 was on contact precautions on the outside of his door to prevent staff who were unaware from entering without appropriate PPE. Review of the 1/15/21, Contact Precautions policy identified staff were to wear a gown and gloves prior to entrance of a residents room when substantial contact would be anticipated, uniforms could be exposed to environmental services, items in a residents room, or has wound drainage. When possible, staff were to dedicate resident equipment and or clean and disinfect equipment. Review of the 10/24/12, Wound Dressing Change policy identified staff were to donn and doff gloves appropriately after each task. There was no mention of how staff were to use equipment between multiple dressing changes. there was also no evidence the policy was reviewed annually for accuracy.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 881	Clara City Care Center has implemented	11/12/21

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F 881	Continued From page 24 facility failed to implement an antibiotic stewardship program which included development of protocols and a system to monitor antibiotic use to ensure appropriate antibiotics were utilized to prevent antibiotic resistance. This had the potential to affect all 36 residents who resided in the facility. Finding include: The facility form, Infection Surveillance Log tracked infections and antibiotic use included resident name, room number, date of onset, signs and symptoms, location/type of infection, identified pathogen, and treatments. However, on 9/22/21, when requested from the facility's infection preventionist, the last recorded month was December 2019. In a review of R8's electronic medical record, documented R8 had been treated for an infected tooth, from 9/07/21 through 9/14/21, with Penicillin VK 500 milligrams (an antibiotic) 1 tab four times a day for 7 days. Although R8's electronic medical record documented the physician's prescribing of R8's antibiotic, why it was prescribed, the dosage and duration of treatment, it was not in the format (line-itemed) so the facility could able to review and compare to other infections diagnosed, without opening each residents individual record. During interview on 9/23/21, at 2:20 p.m. the facility's infection preventionist (IP) stated she had only been in the position of infection preventionist for about 2 weeks receiving her certification in infection control on 9/13/21. IP stated that she had only 5 day of training with the	F 881	an antibiotic stewardship program including development of protocols and a system to monitor antibiotic use and ensure appropriate antibiotics were utilized to prevent antibiotic resistance. All residents have the potential to be affected by this deficient practice. Nursing staff will receive training on Antibiotic stewardship policy/procedure and proper protocols to follow when an antibiotic is prescribed on 11/2/21. DON or designee will audit records of all residents who are currently receiving an antibiotic to ensure the antibiotics are being tracked and that protocols are being followed to ensure they are appropriate monthly and report findings to QAPI committee for review and further action as needed. QAPI Committee Agenda will be changed to reflect addition of Antibiotic Stewardship as a permanent agenda item starting with the November 2021 meeting.	

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F 881	Continued From page 25 previous IP before that IP left the facility. IP stated the facility was documenting resident infections in each individual resident records, rather than on the facility's Resident Illness Report. Although the facility had been recording resident illnesses in each individual records, the facility had not been utilizing the facility forms that would allow for monitoring for patterns, clusters and variables that could prevent further spread of infection. In review of the facility's policy, entitled: Antibiotic Stewardship Policy, last modified 7/08/21, indicated the following: "Purpose: The Clara City Care Center's Antibiotic Stewardship program promotes the appropriate use of antibiotics and a system of monitoring to improve resident outcomes and reduce antibiotic resistance. Antibiotics will be prescribed for the correct indication, dose, and duration to appropriately treat the resident while attempting to reduce the development of antibiotic-resistant organisms or other adverse consequences or outcomes. The Antibiotic Stewardship program will be incorporated in the overall Infection Prevention and Control Program and be reviewed on an annual basis and as needed."	F 881		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and	F 883		11/12/21

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F 883	Continued From page 26 potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883		

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F 883	Continued From page 27 was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 residents (R9 and R23) were offered or received influenza vaccinations during the 2020 Flu season in accordance with the Center for Disease Control (CDC) recommendations. Findings include: R9's Face Sheet (undated) documented the diagnoses of epilepsy and epileptic syndrome (seizure disorder) mild cognitive deficit and neuromuscular dysfunction of the bladder. R9's quarterly Minimum Data Set (MDS) dated 6/14/21, indicated R14 was cognitively intact and received extensive assistance with some of R9's activities of daily living. Review of R9's Immunization Record flow sheet in the R9's electronic record documented the last influenza vaccination he received was dated 11/6/19. Neither R9's paper not electronic medical record documented evidence whether R9 refused or received the influenza vaccination in 2020. During interview on 09/22/21, at 10:00 a.m., R9 could not remember that far back if he refused or received the 2020 influenza vaccination. R23's Face Sheet (undated) documented the	F 883	Resident 9 was offered and refused the influenza vaccine for the 2021 Flu season and refusal was properly documented in his medical record. Resident 23 was offered and received the influenza vaccine for the 2021 Flu season and the vaccination was properly documented in his medical record. All residents have the potential to be affected by this deficient practice. DON or designee will audit all resident records to ensure influenza vaccine was offered or received for the 2021 Flu Season, and any not documented will be corrected and findings reported to QAPI Committee for review and further action. Nursing staff will receive training on offering vaccinations and proper documentation of either receiving the vaccine or refusing it on 11/2/21. DON or designee will audit all new admission monthly for offered or received vaccinations monthly x6 months and findings reported to QAPI Committee for review and further action.	

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F 883	Continued From page 28	F 883		

diagnoses of Parkinson's diease, non-pressure chronic skin ulcers, Alzheimer's and dementia with Lewy bodies. R23's quarterly Minimum Data Set (MDS) dated 8/02/21, indicated R23 was cognitively intact and received extensive assistance with some of R9's activities of daily living.

Review of R23's Immunization Record flow sheet in the R23's electronic record lacked evidence whether R23 had ever received any influenza or pneumococcal vaccinations. However, the infection control preventionist (IC) was able to obtain R23's pneumococcal vaccinations from Minnesota Immunization Information Connection (MIIC).

During interview on 09/22/21, at 10:17 a.m., R23 stated he refused to received the 2020 influenza vaccination.

In an interview on 9/23/21, 1:59 p.m. infection preventionist (IP) confirmed that the facility lacked evidence whether R9 and R23 were offered and/or refused the 2020 Influenza vaccination. The IP stated that it is the practice that letters are sent out to the residents and/or their families for vaccination consent. The IP stated if the resident and/or family refuse, it should be documented in either the residents progress notes or paper medical record. The IP agreed there was no such record in the above-mentioned resident records.

In a review of the facility's policy entitled: Clara City Care Center Admininstration of Influenza Vaccine (last revised 4/3/19) indicated staff were to document each resident's date of influenza vaccine administration and signature pf person administering the vaccine in the chart and on the

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CLARA CITY CARE CENTER	**1012 NORTH DIVISION STREET PO BOX 797 CLARA CITY, MN 56222**

(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 883	Continued From page 29 Influenza Log (to be given to the Business Office). If a resident /responsible party refuses the vaccination or there are contraindications to the resident receiving the influenza vaccine, staff were to document this infomration in the resident's chart. There was no indication the facility had reviewed the policy yearly as required.	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245573	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA CITY CARE CENTER	**1012 NORTH DIVISION STREET PO BOX 797** **CLARA CITY, MN 56222**

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/29/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245573	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA CITY CARE CENTER	**1012 NORTH DIVISION STREET PO BOX 797** **CLARA CITY, MN 56222**

(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 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. Clara City Care Center is a 1-story building with a partial basement. The building was constructed at five different times. The original building was constructed in 1966 and was determined to be of Type II(111) construction. In 1970, an addition was constructed and was determined to be of Type II(111) construction. In 1989, an addition was constructed and was determined to be of Type II (111) construction. The 1997 addition was constructed and was determined to be of Type II(111) construction. The facility added a new kitchen addition in 2010 constructed of type	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245573	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA CITY CARE CENTER	**1012 NORTH DIVISION STREET PO BOX 797** **CLARA CITY, MN 56222**

(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 II(111) construction. Because the original building and the four additions met the construction types allowed for existing buildings, the facility was surveyed as one building. The facility is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 42 beds and had a census of 36 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=E	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, 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	K 353		11/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245573	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA CITY CARE CENTER	**1012 NORTH DIVISION STREET PO BOX 797** **CLARA CITY, MN 56222**

(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 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 edition of the Life Safety Code (NFPA 101), section 9.7.5, and NFPA 25 2011 edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1.2 and 5.2.2.2. These deficient conditions could have a patterned impact on the residents within the facility. Findings include: 1) On 09/22/2021, between 9:00 AM to 1:00 PM, it was revealed that several data cables and low voltage wires were lying on sprinkler pipes in the basement near the maintenance office. 2) On 09/22/2021, between 9:00 AM to 1:00 PM, it was revealed that there were three sprinkler heads covered in dust in the laundry room. These deficient conditions were verified by the Maintenance Supervisor.	K 353	On 9/22/21 all noted data cables and low voltage wires were secured away from sprinkler pipes near the Maintenance office. Additionally on 9/22/21 the 3 noted sprinkler heads in the laundry room were cleaned and dust free. On 9/22/21 the entire basement was checked for wires or cables near sprinkler pipes and hanging wires were secured, and the sprinkler heads throughout the basement were checked and cleaned to ensure no dust could impact their proper functioning. Maintenance director will work with any contractors who install wires or cable in the basement to ensure no wires are left hanging on sprinkler pipes. Maintenance Director will implement a cleaning schedule for sprinkler heads to ensure dust does not build up on sprinkler heads. Maintenance Director or designee will inspect basement for wires/cables hanging on sprinkler pipes and visually observe all sprinkler heads to ensure they remain free of dust monthly x 6 months and report findings to QAPI committee for review and further action.	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet	K 923		11/12/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245573	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA CITY CARE CENTER	**1012 NORTH DIVISION STREET PO BOX 797** **CLARA CITY, MN 56222**

(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 4 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. 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 the storage of the oxygen cylinders per NFPA 101 (2012 edition), Life Safety Code and NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.6.2.3 item 11 and 11.6.5.2 These deficient conditions could have a patterned impact on the residents	K 923	On 9/22/21 all oxygen cylinders were separated based on whether or not they were full with full cylinders being placed in the area furthest from the door of the oxygen room, the empty oxygen cylinder from room 105 was secured in the oxygen room in the area designated for empty	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245573	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2021**

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CLARA CITY CARE CENTER	**1012 NORTH DIVISION STREET PO BOX 797** **CLARA CITY, MN 56222**

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K 923	Continued From page 5 within the facility. Findings include: 1) On 09/22/2021, between 9:00 AM to 1:00 PM, it was revealed that the oxygen cylinders marked full were intermixed in the empty section of the oxygen room. 2) On 09/22/2021, between 9:00 AM to 1:00 PM, it was revealed that in resident room 105, an E-cylinder was unsecured and leaning against a wall. These deficient conditions were verified by the Maintenance Supervisor.	K 923	cylinders. Maintenance director and administrator have updated the oxygen policy/procedure and signage in the oxygen room to ensure staff will secure cylinders in the proper area of the room based on whether they are full or empty. All staff meeting will be held 11/2/21 to review updated oxygen policy/procedure and ensure staff understand proper place to secure oxygen cylinders. Maintenance Director or designee will audit oxygen room for proper placement of empty oxygen cylinders and will also check each occupied room in the facility to ensure any oxygen cylinders are properly secured if present monthly x 6 months and report findings to QAPI committee for review and further action if needed.	

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

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1 245573	**CLARA CITY CARE CENTER**	*K4 **09/22/2021**

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 1

NUMBER OF THIS BUILDING 01

[A] A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

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

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

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

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

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

K321: [ ] K351: [ ]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]
1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]
4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]
7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

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

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

FACILITY DOES NOT MEET LSC:

B. [ ]

K180:

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

*MANDATORY

FIRE SAFETY SURVEY REPORT - 2012 LIFE SAFETY CODE HEALTHCARE

1. (A) PROVIDER NUMBER	1. (B) MEDICAID I.D. NO.
K1 245573	K2

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

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

2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)	
Clara City Care Center	A. BUILDING 01 B. WING C. FLOOR K3	1012 North Division Street Clara City, MN 56222	A. (●) Fully Sprinklered (All required areas are sprinklered) B. ( ) Partially Sprinklered (Not all required areas are sprinklered) C. ( ) None (No sprinkler system) K0180

3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APPROVAL	SURVEY UNDER
[✔] MEDICARE [✔] MEDICAID	09/22/2021 K4	K6	5. (●) 2012 EXISTING 6. ( ) 2012 NEW K7

5. SURVEY FOR CERTIFICATION OF

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

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

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

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

6. BED COMPOSITION				
a. TOTAL NO. OF BEDS IN THE FACILITY 42	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE 0	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE 42	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID 42	e. NUMBER OF NF or ICF/IID BEDS CERTIFIED FOR MEDICAID 0

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

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

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

SURVEYOR (S	TITLE	OFFICE	DATE
Kimberly Swenson	Deputy State Fire Marshal	Minnesota State Fire Marshal Division	09/27/2021
SURVEYOR ID 34764 K10			
FIRE AUTHORITY OFFICI	TITLE Fire Safety Supervisor	OFFICE Minnesota State Fire Marshal Division	DATE 10/21/2021

William Abderhalden 37009

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

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

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

<table>
<tr><th>ID PREFIX</th><th></th><th>MET</th><th>NOT MET</th><th>N/A</th><th>REMARKS</th></tr>
<tr><td>K133</td><td>Multiple Occupancies – Construction Type
Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a two hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows:
• The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1.
• The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters.
18.1.3.5, 19.1.3.5, 8.2.1.3</td><td>◉</td><td>○</td><td>○</td><td></td></tr>
<tr><td>K161</td><td>Building Construction Type and Height
2012 EXISTING
Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7
19.1.6.4, 19.1.6.5
<table>
<tr><th></th><th></th><th>Construction Type</th><th></th></tr>
<tr><td>1</td><td>○</td><td>I (442), I (332), II (222)</td><td>Any number of stories non-sprinklered or sprinklered</td></tr>
<tr><td>2</td><td>◉</td><td>II (111)</td><td>One story non-sprinklered
Maximum 3 stories sprinklered</td></tr>
<tr><td>3</td><td>○</td><td>II (000)</td><td rowspan="4">Not allowed non-sprinklered
Maximum 2 stories sprinklered</td></tr>
<tr><td>4</td><td>○</td><td>III (211)</td></tr>
<tr><td>5</td><td>○</td><td>IV (2HH)</td></tr>
<tr><td>6</td><td>○</td><td>V (111)</td></tr>
<tr><td>7</td><td>○</td><td>III (200)</td><td rowspan="2">Not allowed non-sprinklered
Maximum 1 story sprinklered</td></tr>
<tr><td>8</td><td>○</td><td>V (000)</td></tr>
</table>
Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)
Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.</td><td>◉</td><td>○</td><td>○</td><td>Clara City Care Center is a 1-story building with partial basement. The building was constructed at 5 different times. The original building was constructed in 1966 and was determined to be of Type II(111) construction. In 1970, an addition was constructed and was determined to be of Type II(111) construction. In 1989, an addition was constructed and was determined to be of Type II (111) construction. The 1997 an addition was constructed and was determined to be of Type II(111) construction. The facility added a new kitchen addition in 2010 constructed of type II(111) construction. Because the original building and the 4 additions met the construction types allowed for existing buildings, the facility was surveyed as one building.

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

<table>
<tr><th>ID PREFIX</th><th></th><th>MET</th><th>NOT MET</th><th>N/A</th><th>REMARKS</th></tr>
<tr><td>K161</td><td>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
<table>
<tr><th></th><th></th><th>Construction Type</th><th></th></tr>
<tr><td>1</td><td>○</td><td>I (442), I (332), II (222)</td><td>Not allowed non-sprinklered
Any number of stories sprinklered</td></tr>
<tr><td>2</td><td>○</td><td>II (111)</td><td>Not allowed non-sprinklered
Maximum 3 stories sprinklered</td></tr>
<tr><td>3</td><td>○</td><td>II (000)</td><td rowspan="4">Not allowed non-sprinklered
Maximum 1 story sprinklered</td></tr>
<tr><td>4</td><td>○</td><td>III (211)</td></tr>
<tr><td>5</td><td>○</td><td>IV (2HH)</td></tr>
<tr><td>6</td><td>○</td><td>V (111)</td></tr>
<tr><td>7</td><td>○</td><td>III (200)</td><td rowspan="2">Not allowed non-sprinklered</td></tr>
<tr><td>8</td><td>○</td><td>V (000)</td></tr>
</table>
Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 18.3.5)
Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.</td><td>○</td><td>○</td><td>◉</td><td></td></tr>
<tr><td>K162</td><td>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</td><td>◉</td><td>○</td><td>○</td><td></td></tr>
</table>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
K353	**Sprinkler System – Maintenance and Testing** Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, *Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.* Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked. 09/13/2021 b) Who provided system test. Summit c) Water system supply source. City Water *Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.* 9.7.5, 9.7.7, 9.7.8, and NFPA 25	○	◉	○	1) On 09/22/2021 between 9:00 AM to 1:00 PM, it was revealed several data cables and low voltage wires laying on several sprinkler pipes in the basement near the maintenance office. 2) On 09/22/2021 between 9:00 AM to 1:00 PM, it was revealed in the laundry room there were 3 sprinkler heads covered in dust.
K354	**Sprinkler System – Out of Service** Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24 hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)	◉	○	○	
K355	**Portable Fire Extinguishers** Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, *Standard for Portable Fire Extinguishers.* 18.3.5.12, 19.3.5.12, NFPA 10	◉	○	○	
K361	**Corridors – Areas Open to Corridor** Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1	◉	○	○	

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

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

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

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

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
K421	**High-Rise Buildings** 2012 EXISTING High-rise buildings are protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7 within 12 years of LSC final rule effective date. 19.4.2	○	○	◉	
	2012 NEW High-rise buildings comply with section 11.8. 18.4.2	○	○	◉	
	SECTION 5 – BUILDING SERVICES				
K500	**Building Services – Other** List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	
K511	**Utilities – Gas and Electric** Equipment using gas or related gas piping complies with NFPA 54, *National Fuel Gas Code*, electrical wiring and equipment complies with NFPA 70, *National Electric Code*. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	◉	○	○	
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	◉	○	○	

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
K923	**Gas Equipment – Cylinder and Container Storage** **≥ 3,000 cubic feet** Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. **> 300 but <3,000 cubic feet** Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. **≤ 300 cubic feet** In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of ≤ 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING". Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)	○	◉	○	1) On 09/22/2021 between 9:00 AM to 1:00 PM, it was revealed that the oxygen tanks marked full were intermixed in the empty section of the oxygen room. 2) On 09/22/2021 between 9:00 AM to 1:00 PM, it was revealed in resident room 105 an E-cylinder was unsecured and leaning against a wall.
K924	**Gas Equipment – Testing and Maintenance Requirements** Anesthesia apparatus are tested at the final path to patient after any adjustment, modification or repair. Before the apparatus is returned to service, each connection is checked to verify proper gas and an oxygen analyzer is used to verify oxygen concentration. Defective equipment is immediately removed from service. Areas designated for servicing of oxygen equipment are clean and free of oil, grease, or other flammables. Manufacturer service manuals are used to maintain equipment and a scheduled maintenance program is followed. 11.4.1.3, 11.5.1.3, 11.6.2.5, 11.6.2.6 (NFPA 99)	○	○	◉	

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

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

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

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

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

PROVISION NUMBER(S)	JUSTIFICATION
K400	

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

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

Provider Number	Facility Name	Survey Date
K1		*K4

K6 DATE OF PLAN APPROVAL

K3 MULTIPLE CONSTRUCTION ☐

TOTAL NUMBER OF BUILDINGS _____

NUMBER OF THIS BUILDING _____

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

LSC FORM INDICATOR

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

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

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

*K7 ☐ SELECT NUMBER OF FORM USED FROM ABOVE

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

SMALL (16 BEDS OR LESS)

K8 ☐
1. PROMPT
2. SLOW
3. IMPRACTICAL

LARGE

K8 ☐
4. PROMPT
5. SLOW
6. IMPRACTICAL

APARTMENT HOUSE

K8 ☐
7. PROMPT
8. SLOW
9. IMPRACTICAL

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

K321: ☐ K351: ☐

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

ENTER E – SCORE

K5: ☐ e.g. 2.5

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

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

FACILITY DOES NOT MEET LSC

B. ☐

K0180

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

*MANDATORY