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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: I5YJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00191

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245587**

2.STATE VENDOR OR MEDICAID NO.
(L2) **810542100**

3. NAME AND ADDRESS OF FACILITY
(L3) **EBENEZER CARE CENTER**
(L4) **2545 PORTLAND AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **05/01/2012**

6. DATE OF SURVEY **01/10/2019** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **127** (L18)

13.Total Certified Beds **127** (L17)

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	34	93		
(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:
Eva Loch, Unit Supervisor — 04/15/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Douglas Larson, Enforcement Specialist — 04/15/2019 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/01/1991
(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.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/16/2019
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 15, 2019

REVISED LETTER

Administrator
Ebenezer Care Center
2545 Portland Avenue South
Minneapolis, MN 55404

REVISED LETTER: This letter revises and replaces the letter dated January 11, 2019 to include waiver language.

RE: Project Number S5587029

Dear Administrator:

On January 10, 2019, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Your request for a continuing waiver involving the deficiencies cited under K0161, K0211, K0233 at the time of the November 16, 2018 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 11, 2019

Administrator
Ebenezer Care Center
2545 Portland Avenue South
Minneapolis, MN 55404

RE: Project Number S5587029

Dear Administrator:

On December 4, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 16, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 10, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 31, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 16, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 26, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 16, 2018, effective December 26, 2018 and therefore remedies outlined in our letter to you dated December 4, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit

Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically delivered

REVISED LETTER

CMS Certification Number (CCN): 245587

April 15, 2019

Administrator
Ebenezer Care Center
2545 Portland Avenue South
Minneapolis, MN 55404

RE: This letter revises and replaces the letter dated January 11, 2019 to include waiver language.

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 26, 2018 the above facility is recommended for:

34 Skilled Nursing Facility/Nursing Facility Beds

93 Nursing Facility II Beds

Your facility's Medicare approved area consists of all 34 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K0161, K0211, K0233.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiencies or renew your request for waiver in order to continue your participation in the Medicare and Medicaid Program.

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

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

Please contact me if you have any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245587

January 11, 2019

Administrator
Ebenezer Care Center
2545 Portland Avenue South
Minneapolis, MN 55404

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 26, 2018 the above facility is certified for:

34 Skilled Nursing Facility/Nursing Facility Beds

93 Nursing Facility II Beds

Your facility's Medicare approved area consists of all 34 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: I5YJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00191

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245587**

2.STATE VENDOR OR MEDICAID NO.
(L2) **810542100**

3. NAME AND ADDRESS OF FACILITY
(L3) **EBENEZER CARE CENTER**
(L4) **2545 PORTLAND AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **05/01/2012**

6. DATE OF SURVEY **11/16/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **127** (L18)

13.Total Certified Beds **127** (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
	34	93		
(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:
Dawn Chiabotti, HFE NE II — 12/21/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Douglas Larson, Enforcement Specialist — 01/15/2019 (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
06/01/1991
(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.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
December 4, 2018

Administrator
Ebenezer Care Center
2545 Portland Avenue South
Minneapolis, MN 55404

RE: Project Number S5587029

Dear Administrator:

On November 16, 2018, a standard 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is December 26, 2018.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being

corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by February 16, 2019 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 16, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 11/13/18 through 11/16/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 11/13/18 through 11/16/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.	F 554		12/26/18

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

Electronically Signed | 12/14/2018

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
	245587	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure supervision of resident unable to self-administer medications (SAM) for 1 of 1 resident (R81) observed to self-administer oral medications. Findings include: On 11/15/18, at 8:31 a.m. R81 was observed in her room seated at her over the bed table, bending over from the waist, while in her wheelchair reaching towards the floor. R81 identified that she had dropped her potassium tablet onto the floor and was looking for it. R81 was also observed to have 14 pills in a medication cup on the table. There was no staff present in the room. Licensed practical nurse (LPN)-B was outside of the room, down the hallway, and was not in the position to observe R81. Surveyor notified LPN-B that R81 needed assistance due to dropping a pill onto the floor. LPN-B verified she had left R81 alone with her morning medications. LPN-B further indicated she was a "pool nurse and not sure of the routine so, when I went in there, the resident told me she could take them so I left them; I am unsure the process here." R81's quarterly Minimum Data Set (MDS) dated 10/3/18, indicated R81 was cognitively intact. R81's undated SAM assessment was not completed, and was completely blank. R81's care plan printed on 11/14/18, identified	F 554	R.81 is no longer a resident in our facility Residents residing at the facility will be interviewed regarding their desire to self-administer medications. All residents that want to self-administer will have a Self-Administration of Medication Assessment completed. Care plans will be reviewed and updated as needed to reflect any change. If resident desires self-administration it will be reviewed quarterly, annually, and with significant changes. Self-Administration of Medication policy reviewed. Nursing staff will receive re-education regarding the Self Administration of Medication. Random audits will be completed random 1 time per week for 2 months and 1 time per month for 1 month to ensure compliance. Summary of the audits will be reviewed at the QAA committee. After 3 months recommendations by the committee will be followed. DON will ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 2	F 554		

facility staff to administer medications.

During an interview on 11/15/18, at 1:40 p.m. registered nurse (RN)-A, also nurse manager, revealed R81 did not have a completed SAM assessment or an active order for SAM. RN-A identified it was her expectation that a resident would have a doctor order, completed assessment and updated care plan which stated a resident is able to safely SAM prior to leaving a resident alone with ordered medications.

During an interview on 11/16/18, at 11:39 a.m. the director of nursing (DON) stated it was her expectation for a SAM assessment to be completed and if a resident did not have one, the nurse would stay with the resident and administer the medication.

Review of R81's November 2018, medication administration record indicated medication given by LPN-B on the a.m. of 11/15/18, included: acetaminophen (given for pain management) 1000 milligrams (mg) 2 tablets orally, aspirin (given for atrial fibrillation) 81 mg 1 tablet orally, bumetanide (given for diastolic heart failure) 5 mg 1 tablet orally, calcitriol (given for diabetes) 0.25 mg 1 capsule orally, calcium carbonate (given for hypoparathyroidism) 1000 mg 1 tablet orally, ditiazem (given for atrial fibrillation) 240 mg 1 capsule orally, docusate sodium (given for constipation) 1 tablet orally, fexofenadine (given for allergic rhinitis) 1 tablet orally, gabapentin (given for neuralgia) 1 tablet orally, metoprolol succinate (given for unknown) 200 mg 1 tablet orally, potassium (given for hypokalemia) 40 milliequivalent (mEq) 2 tablets orally, virt-caps

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	245587	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 3 (given for renal insufficiency) 1 mg 1 capsule orally, and vitamin D (given for vitamin deficiency) 400 mg 2 tablets orally. The facility policy Self Administration of medications (SAM) revised 6/2017, included "1. A Self Administration of Medications Assessment will be completed for any resident requesting to administer any medication without the direct supervision of a nurse."	F 554		
F 576 SS=E	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent	F 576		12/26/18

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F 576	Continued From page 4 with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure mail was delivered to residents on Saturday and regularly Monday through Friday. This had the potential to affect all residents in the facility who received personal mail, including but not limited to 7 of 10 residents (R7, R27, R33, R51, R60, R70, R223) at the resident council meeting who voiced concern with mail delivery. Findings include: On 11/15/18, at 9:30 a.m. a group of nine residents, along with the Ombudsman, met to discuss the resident council. When asked whether residents received their mail every day Monday through Saturday, R7, R27, R33, R51, R60, R70 and R223 stated they did not regularly receive their mail on week days and never on Saturdays. R223 stated, "If they catch you in the hallway or leaving the dining room, they might	F 576	Education was done when Administrator was notified of deficient practice. The policy for mail delivery has been reviewed. Mail will be delivered per policy. Some residents have a preference for picking their mail up at the front desk, as per care plan. Random audits on mail delivery will be completed 1 time per week for 2 months and monthly for 1 month. Summary of the audits will be reviewed at the QAA committee. After 3 months recommendations by the committee will be followed. Administrator will ensure compliance	

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F 576	Continued From page 5 give you your mail. Sometimes I wait two-to-three days." During interview on 11/15/18, at 12:08 p.m. the administrative assistant (AA) stated she was responsible to deliver mail to residents during the week, but did not deliver mail on Saturday because she did not work on weekends. AA said the receptionist delivered mail to residents on Saturday. AA also explained that on week days, the receptionist at the front desk notified her when the mail was delivered from the post office. If AA was not available to deliver the mail during the week, she would delegate the task to the receptionist. On 11/15/18, at 12:11 p.m., the receptionist stated, "No one delivers mail on Saturdays because there is no staff. The reception staff has to stay at the desk. The mail sits on the reception desk all weekend until Monday." During an interview on 11/16/18, at 10:39 a.m., the administrator stated she was not aware of this problem and expected personal mail to be delivered to the residents unopened, within 24 hours, each week day and Saturday. The Ebenezer Mail Distribution Policy/Procedure, revised 4/18, directed staff to distribute all mail to the addressed resident, unopened within the same day on which it was delivered to the receptionist. The Active Living Department, receptionist or designated volunteer would deliver the mail to the resident within 24 hours.	F 576		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		12/26/18

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F 609	Continued From page 6 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to submit a vulnerable adult report in a timely manner for 2 of 3 residents (R81 and R1) reviewed for reported incidence of rough treatment.	F 609	Incident of alleged abuse/neglect by R81, R1 has been reported to the designated state agency and thoroughly investigated. Residents R81 and R1 are no longer in the facility.	

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F 609	Continued From page 7 Findings include: R81's admission record printed on 11/14/18, indicated R81 had diagnoses Parkinson disease, diabetes and peripheral vascular disease. R81's quarterly Minimum Data Set (MDS) dated 10/3/18, indicated R81 was cognitively intact and required assistance with all activities of daily living. During an interview on 11/13/18, at 1:07 p.m. R81 identified that she had an "altercation with a staff member, I have no idea who she is ...they don't tell me who they are." R81 stated she was in bed and the NA entered the room to assist R81 in getting up for the day. R81 recalled the NA reached in the cupboard to get her pads and took the pads and slammed them on the table next to R81. R81 stated "it scared the life out I me, I didn't know what she was going to do." R81 indicated the NA yelled at her to "get to the bathroom" and left the room. R81 stated the NA did not return so R81 turned the light on and one of the other aides came to help her to the bathroom. R81 stated she had told the nurse about the incident and further indicated "she honest to goodness scared me." R81 recalled the described altercation occurred on 11/12/18. R81 further stated "the nurse came to me around noon and said the aide was sent home and I haven't seen her again." Review of R81's medical record lacked documentation of the alleged report of mistreatment and/ or documentation regarding the plan and investigation. During an interview on 11/14/18, at 2:21 p.m. licensed practical nurse (LPN)-A stated "when I	F 609	Disposition letters received on 11/20/18 and no further action needed. Incidents of alleged abuse are being reported to the designated state agency and investigated. The vulnerable adult abuse prohibition plan policy was reviewed. Staff re-educated on facility Resident Prevention Plan for reporting allegations of abuse/neglect. Truthpoint satisfaction surveys will continue to be offered quarterly for residents and as needed. Grievance log will be reviewed by administrator for reportable incidents. Random audits will be conducted on incidents of alleged abuse/neglect for timeliness of reporting to the designated state agency 1 time per week for 2 months and 1 time per month for 1 month. Summary of the audits will be reviewed at the QAA committee. After 6 months recommendations by the committee will be followed. Administrator will ensure compliance.	

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F 609	Continued From page 8	F 609		

got here in the morning on 11/12/18, around 7:00 a.m. R81 came out of her room, looked upset and told me that someone had come into her room throwing stuff, yelled and used a rough tone." LPN-A identified R81 had stated to her that she felt scared and intimated by the aide. LPN-A indicated she notified the nurse manager and the nursing assistant (NA) was removed from the schedule and sent home. LPN-A revealed this was the second resident to complain about the same NA. LPN-A identified R1 (the first resident) had reported NA had been rough with her during morning cares prior incident with R81 have happened; LPN-A indicated she immediately notified the nurse manager at that time also.

During an interview on 11/14/18, at 3:28 p.m. registered nurse (RN)-A, also nurse manager, stated she was aware of R81 reported being treated rudely. RN-A recalled R81 indicated she was fearful and had stated "if she got angry I would be scared of her." RN-A indicated the NA was placed on investigative suspension and both the administrator (ADMIN) and interim director of nursing (I-DON) were notified. RN-A explained she was asked to complete a form and then turn it into the I-DON and ADMIN for further review and she was unaware if a vulnerable adult report had been filed. Furthermore, RN-A verified on 11/8/18, RN-A had a conversation with R1 who had reported a concern with the same NA during morning cares. RN-A stated they had planned to talk to the NA regarding R1's report but did not get a chance to prior to R81's report on 11/12/18. RN-A explained R1 had reported to her "oh child the girl today was so rough with me, I told her

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she was hurting me and she told me that if I insulted her she would leave." RN-A further stated that the ADMIN was aware of the allegation.

During an interview on 11/14/18, at 3:44 p.m. R1 stated the NA had come into her room in the morning last week and had been hurting her while putting her clothes on. R1 indicated she was rough when putting her top on and had woke R1 up by pulling on her socks; R1 stated she told the NA "she was hurting me when she was pulling my sock up, I told her again she hurt me and she didn't have to do it anymore so she stopped and I haven't seen her." R1 stated "I told the head nurse she was very rough, she was even rough with my bra and after she hurt me I said to myself I hope she doesn't have to put anything else on me because I felt unsafe." Furthermore, R1 stated "it's the first time in my life I have ever had any one be that rough with me." Review of R1's medical record lacked documentation of the alleged report of mistreatment and/ or documentation regarding the plan and investigation.

R1's admission record printed on 11/16/18, indicated R1 had diagnoses anxiety, depression, and hemiplegia and hemiparesis. R1's quarterly MDS dated 7/31/18, indicated R1 was cognitively intact and required assistance with dressing and personal hygiene.

During an interview on 11/14/18, at 3:59 p.m. the ADMIN stated if there was an allegation of abuse the facility would complete a vulnerable adult report with Minnesota Department of Health. The

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ADMIN stated she was aware of R81 and R1 incidences and explained they did not complete a report for R1 as she did not indicate she was abused during the conversation with RN-A. The ADMIN indicated they did not think the NA was on the schedule until 11/16/18, and planned to interview her on 11/12/18, however stated they misread the schedule and the NA ended up working part of the morning on 11/12/18. The ADMIN identified that she was not aware of R81's report of feeling scared and intimated and had just been made aware of R1's statement which included the NA being rough and hurting R1 prior to this interview. The ADMIN confirmed neither report had been submitted as a vulnerable adult report at the time of this interview. The ADMIN further stated regarding R1 "with a quote like that yes that would have been reported immediately."

During an interview on 11/14/18, at 4:41 p.m. with RN-A, I-DON and ADMIN; RN-A identified she had notified the I-DON on 11/9/18, that R1 had reported on 11/8/18, being treated roughly and that the NA hurt R1. RN-A further identified on 11/12/18, both the ADMIN and I-DON were aware the NA had slammed an incontinent product on the night stand and yelled at R81. The I-DON identified she was unaware of the situation on 11/12/18, as she was not working, however she felt the 11/8/18, incident reported by R1 was a customer service issue and had indicated a grievance form had been completed. The I-DON stated at the time of this interview it was her first time being made aware of R1's report of the NA being rough and hurting R1. The I-DON indicated she would have investigated

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stating "I have 2 hours to determine if it truly meets a vulnerable adult report standard." The I-DON further stated R1 has complained about her feet being sensitive in the past so at that point we did not have the NA on the schedule and the R1 was not fearful and/ or injured "to me that doesn't rise to the level of a VA [vulnerable adult]." Furthermore, the I-DON indicated had the NA been on the schedule they would have called her immediately. The director of social services (DSS) entered and stated she had been informed via email by a staff who had completed a survey that R1 reported to her that she notified the NA she was hurting her and the NA laughed. The DSS stated she immediately notified RN-A who then initiated the investigation.

On 11/15/18, 11:43 a.m. surveyor was notified the facility had filed vulnerable adult reports (after the concerns were brought into their attention by surveyor) for both R81 and R1.

The facility policy Vulnerable Adult- Abuse Prohibition Plan revised date 5/2018, indicated "alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported, and a report made immediately, but not later than 2 hours after the allegation is made ...or not later than 24 hours if the events that cause the allegation do not involve abuse ..."; "The report will be made, to the Minnesota Department of Health (MDH)/OHFC." The policy identified "9. Abuse. a. Willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish

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F 609	Continued From page 12 and b ... Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm."	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to protect the residents who resided on the third floor unit following an allegation of mistreatment for 2 of 3 residents (R81 and R1) reviewed for reported incidence of rough treatment. Findings include: During an interview on 11/13/18, at 1:07 p.m.	F 610	Incident of alleged abuse/neglect by R81, R1 has been reported to the designated state agency and thoroughly investigated. Residents R81 and R1 are no longer in the facility. Disposition letters received on 11/20/18 and no further action needed. Incidents of alleged abuse are being reported to the designated state agency and	12/26/18

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F 610	Continued From page 13 R81 identified that she had an "altercation with a staff member, I have no idea who she is ...they don't tell me who they are." R81 stated she was in bed and the NA entered the room to assist R81 in getting up for the day. R81 recalled the NA reached in the cupboard to get her pads and took the pads and slammed them on the table next to R81. R81 stated "it scared the life out I me, I didn't know what she was going to do." R81 indicated the NA yelled at her to "get to the bathroom" and left the room. R81 stated the NA did not return so R81 turned the light on and one of the other aides came to help her to the bathroom. R81 stated she had told the nurse about the incident and further indicated "she honest to goodness scared me." R81 recalled the described altercation occurred on 11/12/18. R81 further stated "the nurse came to me around noon and said the aide was sent home and I haven't seen her again." Review of R81's medical record lacked documentation of the alleged report of mistreatment and/ or documentation regarding the plan and investigation. R81's admission record printed on 11/14/18, indicated R81 had diagnoses Parkinson disease, diabetes and peripheral vascular disease. R81's quarterly Minimum Data Set (MDS) dated 10/3/18, indicated R81 was cognitively intact and required assistance with all activities of daily living. During an interview on 11/14/18, at 2:21 p.m. licensed practical nurse (LPN)-A stated "when I got here in the morning on 11/12/18, around 7:00 a.m. R81 came out of her room, looked upset and told me that someone had come into	F 610	investigated. The vulnerable adult abuse prohibition plan policy was reviewed. Staff re-educated on facility Resident Prevention Plan for reporting allegations of abuse/neglect. Truthpoint satisfaction surveys will continue to be offered quarterly for residents and as needed. Grievance log will be reviewed by administrator for reportable incidents. Random audits will be conducted on incidents of alleged abuse/neglect for timeliness of reporting to the designated state agency 1 time per week for 2 months and 1 time per month for 1 month. Summary of the audits will be reviewed at the QAA committee. After 6 months recommendations by the committee will be followed. Administrator will ensure compliance.	

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F 610	Continued From page 14	F 610		

her room throwing stuff, yelled and used a rough tone." LPN-A identified R81 had stated to her that she felt scared and intimated by the aide. LPN-A indicated she notified the nurse manager and the nursing assistant (NA) was removed from the schedule and sent home. LPN-A revealed this was the second resident to complain about the same NA. LPN-A identified R1 had reported NA had been rough with her during morning cares; LPN-A indicated she immediately notified the nurse manager.

During an interview on 11/14/18, at 3:44 p.m. R1 stated the NA had come into her room in the morning last week and had been hurting her while putting her clothes on. R1 indicated she was rough when putting her top on and had woke R1 up by pulling on her socks; R1 stated she told the NA "she was hurting me when she was pulling my sock up, I told her again she hurt me and she didn't have to do it anymore so she stopped and I haven't seen her." R1 stated "I told the head nurse she was very rough she was even rough with my bra and after she hurt me I said to myself I hope she doesn't have to put anything else on me because I felt unsafe." Furthermore, R1 stated "it's the first time in my life I have ever had any one be that rough with me." Review of R1's medical record lacked documentation of the alleged report of mistreatment and/ or documentation regarding the plan and investigation.

R1's admission record printed on 11/16/18, indicated R1 had diagnoses anxiety, depression, and hemiplegia and hemiparesis. R1's quarterly MDS dated 7/31/18, indicated R1 was cognitively

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intact and required assistance with dressing and personal hygiene.

During an interview on 11/14/18, at 3:28 p.m. registered nurse (RN)-A, also nurse manager, verified on 11/8/18, RN-A had a conversation with R1 who had reported a concern with the same NA during morning cares. RN-A stated they had planned to talk to the NA regarding R1 report but did not get a chance to prior to R81's report on 11/12/18. RN-A confirmed the NA worked with resident's on 11/12/18, as the facility had mistakenly misread the schedule. RN-A stated R1 had reported to her "oh child the girl today was so rough with me, I told her she was hurting me and she told me that if I insulted her she would leave." RN-A further explained that she was aware of R81 reported being treated rudely on 11/12/18. RN-A recalled R81 indicated she was fearful and had stated "if she got angry I would be scared of her." RN-A indicated the NA was immediately placed on investigative suspension and both the administrator (ADMIN) and interim director of nursing (I-DON) were notified. RN-A explained she was asked to complete a form and then turn it into the I-DON and ADMIN for further review and she was unaware if a vulnerable adult report had been filed.

During an interview on 11/14/18, at 3:59 p.m. the ADMIN stated she was aware of R81 and R1 incidences. The ADMIN indicated they did not think the NA was on the schedule until 11/16/18, and planned to interview her on 11/12/18, however confirmed they misread the schedule and the NA ended up working part of the

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F 610	Continued From page 16 morning on 11/12/18, and after R81's allegation removed her from the floor immediately. During an interview on 11/14/18, at 4:41 p.m. with RN-A, I-DON and ADMIN; RN-A identified she had notified the I-DON on 11/9/18, that R1 had reported on 11/8/18, being treated roughly and that the NA hurt R1. RN-A further identified on 11/12/18, both the ADMIN and I-DON were aware the NA had slammed an incontinent product on the night stand and yelled at R81. The I-DON indicated had the NA been on the schedule they would have called her immediately to interview her prior to working her next scheduled shift. The facility policy Vulnerable Adult- Abuse Prohibition Plan revised date 5/2018, indicated "Internal Reporting Procedure 1 ...Steps must be taken to ensure that no resident in the facility remains in danger of maltreatment ...5. Immediate steps are taken to protect the vulnerable adult from harm while the situation is being investigated ...6 ...the employee in question may be interviewed, and suspended pending investigation. This is for the protection of the resident."	F 610		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to accurately code a comprehensive	F 641	R 117 is no longer a resident in the facility.	12/26/18

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F 641	Continued From page 17 assessment for 1 of 2 residents reviewed for closed records (R117). Findings include: R117 was admitted to the facility on 5/17/18. R117's care plan dated 7/5/18, indicated a terminal diagnosis related to end stage due to chronic obstructive pulmonary disorder (a lung disease that gets worse over time and makes it harder to breathe). A progress note dated 6/25/2018, indicated R117 was enrolled in a hospice program effective that date. A progress note dated 9/23/18, indicated that R117 died. A significant change Minimum Data Set (MDS) for R117 was completed on 7/1/18. It did not indicate R117 was receiving hospice cares. On 11/15/18, at 1:53 p.m. the MDS nurse stated a significant change MDS should be completed anytime a resident enrolled in hospice. The MDS nurse explained hospice enrollment should be captured in the MDS under section O0100. The MDS nurse confirmed that a significant change MDS was completed for R117 on 7/1/18, however it did not indicate R117 was receiving hospice cares. The MDS nurse confirmed that R117 was on hospice at that time and that information should have been captured within the MDS. A facility policy about MDS significant change was requested but not provided.	F 641	The MDS nurse involved is no longer employed in facility. MDS for current Residents on hospice were reviewed for accuracy and they were all coded correctly. One on one session was conducted with current MDS nurse to ensure MDS coding is appropriate prior to submission. DON or MDS nurse will complete an audit on residents who sign on to hospice to assure accurate coding of hospice for the MDS for 3 months. Summary of the audits will be reviewed at the QAA committee. After 3 months recommendations by the committee will be followed. DON will assure accurate information is entered into the MDS.	

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F 641	Continued From page 18 The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2018, identified Section O0100K as the place to code residents identified as being in a hospice program. Steps of assessment indicated "Review the resident ' s medical record to determine whether or not the resident received or performed any of the treatments, procedures, or programs within the last 14 days.", and Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions."	F 641		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide meaningful and individualized activity programs for 2 of 5 residents (R65, R115) reviewed for activities. Findings include:	F 679	Comprehensive activity assessments have been updated to meet the individual needs of R65 and R115. Activity care plans for R65 and R115 have been updated.	12/26/18

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F 679	Continued From page 19 During interview on 11/13/18, at 2:42 p.m. R65 stated she felt that she did not have enough to do throughout the day. R65 stated she was not normally allowed to leave the floor that she lived on. R65 stated she really enjoyed the clay modeling classes and the watercolor painting classes. R65 stated the facility did not offer the clay modeling class anymore and the painting class was only once per week. R65 stated she currently only liked the watercolor painting activity and besides that, she did not feel like she had anything to do for the rest of the week. R65 explained how much she enjoyed art classes and showed surveyor many of her paintings displayed in her room that she had made. R65 pointed to her activities calendar in her room which listed what activities were taking place on her floor (2S) only. R65 stated she used the calendar to keep track of the activities schedule. R65 further explained that nobody invited her to any activities or rarely invited her to leave the floor she lived on since she was unable to leave the floor herself. R65's annual Minimum Data Set (MDS) dated 9/20/18 indicated resident had moderate cognitive impairment, and it was very important for R65 to do her favorite activities. R65's care plan dated 10/5/18, indicated socialization problems as a focus. The goals indicated R65 would participate in activities of interest including art. Interventions included to invite and escort to programs as desired. R65's activity log from June 2018 through November 2018, was reviewed in addition to the	F 679	Staff will identify residents who are at risk for isolation or socialization problems and complete the activities assessment and update the care plan as appropriate. Active living staff will complete assessments on residents on the unit. Staff will be re-educated on engaging residents in activities and on our activity kits. Audits will be completed 1 time per week for 2 months and 1 time per month for 1 month to ensure compliance. Summary of the audits will be reviewed at the QAA committee. After 3 months recommendations by the committee will be followed. Active living director will ensure compliance.	

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facility activity calendar schedules. The activity log indicated R65 would participate in both "Clay Creations" and "Painting with Cindy" when the activities were offered on 2S. It further indicated that when those activities occurred in a different location that R65 did not attend.

On 11/13/18, at 3:23 p.m. the activities director (AD) stated that 2S had their own activities calendar since it was a locked unit and that there was another activities calendar for the rest of the facility.

On 11/14/18, at 2:04 p.m. R65 was up walking with her walker and told surveyor she thought there was a watercolor painting class that afternoon. R65 proceeded to the dining room to wait for the class to begin. At 3:24 p.m. R65 was observed actively participating in the painting class taking place in the dining room.

On 11/15/18, at 9:33 a.m. nursing assistant (NA)-C stated R65 was independent during the day and would walk out to the dining area sometimes to participate in group activities. NA-C was not aware of R65 refusing any activities. NA-C stated there were activities offered on the 2S unit but was unsure how the residents were able to attend activities off the unit. NA-C stated he did not know any specific activities R65 enjoyed.

On 11/15/18, at 12:03 p.m. the AD explained he was new to the role. AD stated there were issues with providing activities for residents that lived on 2S. AD stated the facility was working on providing more activity options and individualized

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activity plans for the residents that lived on 2S but they had not achieved their goal yet.

On 11/16/18, at 10:22 p.m. registered nurse (RN)-B (also unit manager), stated R65 was able to participate in activities off the unit with supervision. RN-B stated somebody from the activities department was expected to invite residents to activities.

R115 medical diagnosis included hearing loss, vision loss, and bipolar disorder.

R115's care plan revised 11/12/18, indicated risk for social isolation as a focus. Interventions included R115 enjoyed walking, being outside and interacting with dogs.

During observation on 11/13/18, at 2:23 p.m. R115 attempted to stand up from wheelchair in the dining room two times in a row. Staff then wheeled him back to dining room table. At 2:25 p.m. R115 attempted to stand again and staff then brought R115 to the bathroom. At 2:40 p.m. R15 was observed back at dining room table. R115 was fidgeting with his hands and reaching out touching the table. At 3:14 p.m. nursing assistant (NA)-B was sitting next to R115 at the table. R115 continued to fidget with his hands at that time and a movie had begun playing on a TV on the other side of the dining room. NA-B told R115 to look at the TV. NA-B did not offer any activities for R115 to do. Later at 5:17 p.m. R115 was observed to be sitting in dining area fidgeting with his hands again. No activities or walking were offered by staff.

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During observation on 11/14/18, at 1:48 p.m. R115 was observed sitting in dining room with NA-C sitting next to him. R115 appeared to be signing with hands to NA-C. Very quiet music was on in the background. At 2:04 p.m. staff started a movie on the TV on the other side of the room. R115 was observed until 3:27 p.m., during that time, no individualized activities were offered for R115.

R115's admission Minimum Data Set (MDS) dated 5/1/18 indicated R115 had moderate cognitive impairment. In addition the MDS indicated it was very important for R115 to have animals around, do his favorite activities and to get outside when the weather was good.

R115's activity log from June 1-November 15, 2018 was reviewed. It indicated R115 had received dog visits a total of 3 times. It did not indicate that R115 had participated in an activity outside. The facility activity calendars for 2S and the rest of the building were reviewed. It indicated there were outside activities weekly for garden walks and lake outings that were not on the activity calendar for 2S.

R115's active living quarterly progress notes dated 8/9/18 and 11/8/18 were reviewed. They indicated R115 was stable with his participation but did not indicate any activities besides one animal visit that R115 had participated in.

On 11/15/18, at 9:33 a.m. NA-C stated R115 could not do any activities because he was blind. NA-C stated he did not know anything that R115 liked to do or have any interest in. NA-C stated

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they tried to use basic sign language signs to communicate with R115 but R115 did not seem to understand much. NA-C also stated R115 was able to walk but it was unsafe because he was blind.

On 11/15/18, at 9:27 a.m. R115 was observed to be sitting at dining room table not doing anything. At 9:41 a.m. R115 continued sitting at the dining room table not doing anything. At 10:06 a.m. R115 continued sitting at the dining room table fidgeting with his hands. No activities were observed to be offered to R115.

On 11/15/18, at 12:03 p.m. the AD explained he was new to the role. AD stated there were issues with providing activities for residents that lived on 2S. AD stated the facility was working on providing more activity options and individualized activity plans for the residents that lived on 2S but they had not achieved their goal yet.

On 11/15/18, at 1:14 p.m. registered nurse (RN)-C stated sometimes she would give R115 some items to play with such as a puzzle or a ball. RN-C stated there were no group activities that R115 participated in. RN-C also stated R115 needed to walk with physical therapy (PT).

On 11/16/18, at 10:05 a.m. NA-D stated R115 could walk with staff and that PT was working on a walking program for him. NA-D stated when there was a music activity in the dining room sometimes she would sit next to him and tap with the rhythm of the music on the table so he could feel the vibrations. However NA-D stated she was not sure of any specific activities that R115

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F 679	Continued From page 24 enjoyed. On 11/16/18, at 10:12 a.m. RN-B who acted as unit manager stated communicating with R115 was difficult and sign language people said he was not making sense with his sign language anymore. RN-B stated R115 sometimes like folding cloth napkins if they were put in front of him and also enjoyed the clay works class. RN-B stated PT was working on his walking program and he also expected staff to walk with R115 every day as well. RN-B also stated it was okay for R115 to go outside with supervision. RN-B further stated somebody from the activities department was expected to invite residents to activities. A facility policy titled Active Living revised April 2018, was provided. It indicated that active living staff would chart any changes and resident responses to activities in a progress note as needed. It did not indicate whose responsibility it was to invite or transport residents to activities.	F 679		
F 689 SS=E	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 document	F 689	R81 is no longer in the facility.	12/26/18

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F 689	Continued From page 25 review, the facility failed to ensure a comprehensive assessment, ongoing monitoring, evaluation for safe smoking and supervision for smoking materials was completed for 2 of 2 residents (R81 and R27) reviewed for smoking. In addition the facility failed to implement individualized, resident-centered interventions as identified in the care plan to reduce risk of falls for 2 of 6 residents (R115, R109) reviewed for accidents. Findings include: R81's admission record printed on 11/14/18, indicated R81 was admitted to the facility on 6/27/18. R81's diagnosis report printed on 11/14/18, indicated R81 had diagnoses including Parkinson disease, generalized muscle weakness and difficulty in walking. During an interview on 11/13/18, at 1:19 p.m. R81 stated that she smoked and would independently wheel herself, while in her wheelchair, to the sidewalk directly outside of the front door to the facility. R81 identified she did not smoke in the designated smoking area, which was near the end of the driveway on the sidewalk next to the street in front of the facility. R81 verbalized she was able to wheel herself down the driveway, however was unable to wheel herself back up the driveway as there was a slight incline and she did not have enough strength. R81 was observed to have had her open pack of cigarettes and lighter stored in unlocked top drawer of her nightstand in her room.	F 689	Facility is smoke free environment. A smoking assessment has been completed on R27 by 12/13/18. The care plan for R27 has been updated. The policy and procedure for tobacco free/no smoking will be reviewed and revised. Staff re-education will be completed on smoking policy. Residents who pass the smoking assessment will have 1:1 meeting regarding facility smoking expectations. A Random audit will be completed daily for 2 weeks and weekly for 2 and a half months. Summary of the audits will be reviewed at the QAA committee. After 3 months recommendations by the committee will be followed. Administrator will ensure compliance. A new fall risk assessment was completed to identify any new interventions for R109 and R115. The fall prevention policy was reviewed. Staff re-education will be completed on fall prevention policy. IDT will review fall risk incidents at morning huddle Monday through Friday. Random audits will be completed 1 time a week for 3 monthly to ensure appropriate interventions are initiated. Summary of the audits will be reviewed at the QAA committee. After 3 months recommendations by the committee will be followed. DON will ensure compliance	

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On 11/14/18, at 8:57 a.m. R81 was observed outside on the facility property, on the sidewalk to the side of the facility front door smoking a cigarette. R81 did not have any burns on her fingers and/ or clothing, extinguished her cigarette onto the ground and then placed the cigarette butt into an empty plastic bucket near the entrance.

R81's quarterly Minimum Data Set (MDS) dated 10/3/18, indicated R81 had intact cognition and required supervision, oversight and encouragement of one person for locomotion off unit. R81's MDS section J1300 Current Tobacco Use was not completed.

R81's smoking assessment dated 10/4/18, was reviewed and lacked evidence of what R81 would have done in the event of a fire and further lacked summary and analysis of R81's smoking plan. The smoking assessment also identified R81 as able to independently transport self to and from designated smoking area.

R81's care plan printed on 11/14/18, identified R81 as a smoker and interventions included instruction about the facility policy on smoking: locations, times, safety concerns and to notify charge nurse immediately if there was suspected violation of the facility smoking policy.

During an interview on 11/14/18, at 2:01 p.m. licensed practical nurse (LPN)-A verified R81 smoked independently. LPN-A identified R81 would wheel herself down to the front of the facility building, on facility property, and smoke on the sidewalk near the entrance of the facility.

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LPN-A further stated R81 had notified her that "she cannot physically get down the hill" and further stated R81 verbalized she would remain smoking on the side front entry way of the building. LPN-A indicated the assigned nurse was to complete a smoking assessment upon admission, however LPN-A was unsure when a follow-up assessment would be completed.

During an interview on 11/16/18, at 10:29 a.m. registered nurse (RN)- A, also nurse manager, stated that she had completed the smoking assessment dated 10/4/18, by observing R81 while smoking. RN-A reviewed R81's smoking assessment dated 10/4/18, and identified "section E. safety 8. If there was a fire, can they recite what they would do (Ask the resident to tell you)" and "Plan:" were blank and had not been addressed. RN-A confirmed R81's smoking assessment indicated R81 was able to independently "transport herself to and from (including entering and exiting) designated smoking area." RN-A explained that she was unaware R81 was not able to independently get to and from the designated smoking area and identified that she would have completed another smoking assessment had she known.

During an interview on 11/16/18, at 11:03 a.m. director of nursing (DON) and administrator (ADMIN) indicated all residents who resided at the facility and smoked were required to smoke on the sidewalk at the end of the driveway in front of the building. The ADMIN indicated they had spoken to R81 and offered to go out of the side of the building where the sidewalk was flatter. The DON identified it was an expectation that a

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smoking assessment should have been re-evaluated when a resident was no longer able to perform one or more of the safety components.

The facility policy Tobacco Free/ No smoking effective date 6/2017, indicated "Residents and visitors are not allowed to smoke or use tobacco in Ebenezer buildings or on Ebenezer property." "Procedure: Residents and visitors: 2. Residents or visitors who are found smoking in Ebenezer buildings or on the premises will be asked to extinguish smoking materials immediately ...3. If a resident or visitor insists on smoking in violation of this policy, the unit manager, house supervisor or administrator should be notified to address the situation. The policy lacked evidence of how others safety on the unit would be addressed for storage of smoking materials.

R 27
On 11/13/18, at 2:25 p.m. cigarette odor (smoke) was noted in R27's room. This was immediately reported to a registered nurse (RN-A). RN-A approached R27 in her room and found her to have three used cigarette butts in her pocket and four in various places throughout her room. R27 stated she did not want to litter and because there were no cigarette receptacles outside of the building, near the entrance, she brought them inside and threw them out in her personal garbage can in her room. R27 further explained that she did not use the cigarette receptacle "down the hill, next to the street" because she had witnessed three car accidents while smoking in this designated smoking area and did not feel

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safe. Also observed in R27's room on her dresser were seven unopened packs of cigarettes and two lighters. In addition, one open pack of cigarettes and a lighter was observed on R27's bedside table. She denied using protective equipment when she smoked or smoking in her room.

On 11/13/18, at 2:51 p.m., a licensed practical nurse (LPN)-C verified R27 had seven used cigarette butts in her personal garbage can in her room. LPN-C removed the cigarette butts.

On 11/13/18, at 2:54 p.m., a housekeeper (H)-A stated she observed "used" cigarette butts in R27's personal garbage can "nearly every day". H-A added she often found used butts on R27's bedside table and floor and that R27 regularly kept her cigarette and lighter supply in her room. H-A stated she reported this to the director of environmental services and the nursing supervisor "a couple of months ago" but still witnessed used cigarette butts in R27's room and garbage can daily.

On 11 /13/18, at 5:45 p.m., a regular garbage can (not a garbage can that was manufactured for the purpose of safe handling or extinguishing of hot material including cigarette butts) was observed near the front entrance, however a cigarette receptacle was noted down the hill, near the street in the front side of the facility in the designated smoking area.

R27's Admission Record noted she was admitted to the facility on 11/17/17. The Ebenezer Smoking Assessment dated 10/10/18, indicated

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R27 was a frequent smoker morning, afternoon, evening and night and was able to dispose of ashes and cigarette butts safely without assistance. No other smoking assessments were available for review.

Although the Admission Minimum Data Set dated 11/24/17, noted R27 smoked cigarettes. However a Care Area Assessment was not developed.

The current care plan, revised 11/28/17, identified R27 at risk due to impaired vision related to a diagnosis of Glaucoma and also at risk for impaired cognition related to periods of confusion. The care plan also indicated R27 had behavior health related to her diagnosis of Schizoaffective Disorder, PTSD (Post Traumatic Stress Disorder) with a history of hallucinations and paranoia as well as trouble concentrating. The care plan, created 5/11/18, identified R27's as a smoker and directed staff to instruct her about the facility policy on smoking: locations, times, safety concerns and to notify charge nurse immediately if it is suspected violation of facility smoking policy.

On 11/14/18, at 10:04 a.m., R27 stated she was not educated prior to this incident regarding the risks of bringing used cigarettes butts back to her room or that she should extinguish and leave the butts outdoors. R27 stated she often forgot to leave the cigarette butts outside. However, she "cleaned out her pockets today" and did not bring the butts back to her room.

On 11/14/18, at 2:59 p.m., the Director of

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Environmental Services (DES) stated he did not recall any reports regarding R27 bringing used cigarette butts back to her room after smoking outdoors or placing the use butts in her garbage can. The DES stated this would be a "big red flag." The DES stated the facility did not have a policy regarding cigarette butts and/or bringing the butts into the building but would expect these types of incidents to be reported to housekeeping.

On 11/16/18, at 11:02 a.m., the Director of Nursing (DON) and the administrator, in a joint interview, stated R27 had been assessed to have safe practices when extinguishing her cigarettes and when going down the incline (hill) in the front of the building to the designated smoking area. The DON stated a new cigarette receptacle was placed near the front of the building and the facility had decided residents who smoked could now go to the back of the building which was an easier and safer alternative. The DON also stated she expected staff to report these incidents immediately and residents should be reassessed as needed to ensure their safety. She stated the facility was in the process of re-evaluating their smoking and smoking cessation policy.

The Ebenezer Policy/Procedure for Tobacco Free/No Smoking, revised 6/17 stated residents and visitors are not allowed to smoke or use tobacco in Ebenezer buildings or on Ebenezer property.

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R115 was admitted to the facility on 4/24/18. Review of progress notes indicated R115 had fallen 17 times since admission.

R115 medical diagnosis included bipolar disorder, vision loss and hearing loss.

The 'Ebenezer Care Center-Deaf Residents who use Sign Language form, updated November 8, 2018 indicated R115 was deaf and blind. It further indicated R115 was sometimes able to use minimal sign language skills. It recommended for staff to slowly approach resident from the front, move slowly and make sure that R115 was aware of staff presence (gently touch on shoulder).

R115's care plan dated 11/12/18 indicated risk for falls as a focus. Interventions included assist to use hand rails when walking in the hallway, attempt to walk with R115 during periods of restlessness, offer busy board during periods of restlessness, offer food and fluids when noted to be restless, and offer toileting if noted to be restless. R115's care plan also indicated limited physical mobility related to weakness, difficulty finding destinations due to poor vision. Goal indicated R115 would increase level of mobility by walking to and from dining room. Interventions included hand hold assist with ambulation.

On 11/13/18, at 2:30 p.m. R115 was observed sitting at the dining room table fidgeting his hands. At 3:14 p.m. R115 attempted to stand repeatedly, nursing assistant (NA)-B told R115 to sit down and to look at the television.

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On 11/13/18, at 5:17 p.m. R115 was sitting at dining room table fidgeting. At 5:44 p.m. R115 attempted to stand and staff told him to sit down. At 5:47 p.m. R115 again attempted to stand, NA-B told R115 to sit down. At 5:51 p.m. R115 again attempted to stand and NA-B again told R115 to sit down. At 6:04 p.m. R115 again attempted to stand twice with staff telling R115 to sit down and pulling down on the back of his shirt.

On 11/14/18, R115 was continuously observed from 1:48 p.m. to 3:27 p.m. At 1:48 p.m. nursing assistant (NA)-C was sitting with R115 at the dining room table and R115 was attempting to use sign language to communicate with NA-C. At 1:49 p.m. R115 started wheeling himself back from the table, staff stopped him and brought him back to the table and locked his wheelchair. At 2:02 p.m. R115 attempted to stand up and sat down. At 2:03 p.m. R115 attempted to stand up twice, NA-D assisted him to sit down and rubbed his back. Another staff came up and unlocked R109's wheelchair breaks. At 2:04 p.m. R115 stood up and wheelchair rolled back quickly while he was standing, staff ran over to assist him back to sitting. A movie was turned on at that time in the dining room. At 2:14 p.m. R115 began wheeling away from table and NA-C rolled him back and attempted to use signs with him. At 2:16 p.m. R115 attempted to stand again and sat down. At 2:22 p.m. R115 attempted to stand and wheelchair rolled back again quickly, staff ran to assist R115 and help him sit at dining room table again. At 3:25 p.m. R115 attempted to stand again with wheelchair rolling back and

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NA-B took him the bathroom at that time. Until staff took R115 to the bathroom, no care planned fall reduction interventions were attempted.

On 11/15/18, at 9:27 a.m. R115 was observed sitting at the dining room table in a wheelchair with no activities going on. At 9:41 a.m. R115 continued sitting in dining room. At 10:06 a.m. R115 was observed sitting in dining room fidgeting with his hands. His wheelchair was locked at this time.

On 11/15/18, at 9:33 a.m. NA-C stated R115 tried to stand all the time so staff had to watch him closely so he did not fall. NA-C stated R115 had the physical strength to walk but they did not walk with him because it would be dangerous for R115 to walk because he was blind. NA-C stated R115 became agitated occasionally. NA-C stated he did not know anything that R115 liked to do or have any interest in and stated R115 would not be able to participate in activities due to his blindness. NA-C stated they tried to use basic sign language signs to communicate with R115 but R115 did not seem to understand much.

On 11/15/18, at 1:14 p.m. registered nurse (RN)-C stated sometimes she would give R115 some items to play with such as a puzzle or a ball. RN-C stated there were no group activities that R115 participated in. RN-C also stated R115 was able to walk and walked with physical therapy (PT) using a hand for guidance due to visual impairment. RN-C stated for fall prevention staff should not lock his wheelchair and staff should always be close by. At that time R115 was observed sitting at the dining room table and

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appeared to be attempting to use sign language. No attempts were observed by staff to communicate with him.

On 11/16/18, at 10:05 a.m. NA-D stated R115 could walk and that PT was working on a walking program for him. NA-D stated when there was a music activity in the dining room sometimes she would sit next to him and tap with the rhythm of the music on the table so he could feel the vibrations. However NA-D stated she was not sure what R115 liked to do during the day. NA-D stated she was not sure if his wheelchair breaks should be locked or not locked. NA-D explained staff had told her both to keep them locked and to unlock them. NA-D stated she felt like R115 was safer with breaks on because otherwise wheelchair would roll back when R115 was trying to stand. NA-D stated she was not sure what helped when R115 tried to stand and for fall prevention. NA-D stated when she was working with him she would rub his back and use a calm manner and she thought that helped.

On 11/16/18, at 10:12 a.m. RN-B who acted as unit manager stated communicating with R115 was difficult and sign language people said he was not making sense with his sign language anymore according to the sign language interpreter. RN-B stated R115 sometimes liked folding cloth napkins if they were put in front of him and also enjoyed the clay works class. RN-B stated PT was working on his walking program and he also expected staff to walk with R115 every day as well. RN-B stated R115 was previously assessed for an anti-rollback feature for his wheelchair but it had been determined

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unsafe for R115 so he currently had an anti-tilt feature on his wheelchair. RN-B stated after each fall of R115's there was an interdisciplinary team meeting the next day to determine the cause of the fall. RN-B stated currently staff was doing one to one staff coverage with R115 for fall prevention but that was just temporary. RN-B also stated R115 was to be in dining room at all times when he was awake. RN-B also verified that NAs were expected to walk with R115 every few hours throughout the day.

R115's PT notes were reviewed. The discharge summary dated 5/7/18, indicated that R115 and caregivers were instructed on resident walking with a staff member for guidance due to decreased vision and cognition. The treatment encounter note dated 11/9/18, indicated staff training to facilitate walking program was done with the charge nurse. PT demonstrated walking with R115, then had charge nurse take over and walk another 150 feet with R115 while PT wheeled wheelchair close behind. It further indicated nurse was instructed in a walking program for R115 to walk twice daily.

A facility Fall Prevention Policy revised August 2018, was provided. It indicated that preventative measures should be taken to decrease the number of falls whenever possible.

R109 was admitted to the facility on 10/16/17, with medical diagnoses that included dementia.

R109's care plan dated 11/2/18, indicated R109 was at a moderate risk for falls related to wandering, impaired mobility and impaired

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cognition. Interventions included wearing appropriate footwear when in wheelchair or gripper socks if R109 did not want to wear shoes, self-lock brakes to wheelchair and offer to lie down after each meal. R109's care plan also indicated physical and verbal behaviors as a focus. It further indicated R109 was a possible elopement risk due to wandering in his wheelchair. Interventions included to distract wandering by offering diversions and noted R109 enjoyed looking out windows.

Review of R109's progress notes and interdisciplinary team reviews revealed that R109 had 4 falls since July 16, 2018:
- A fall on 7/18/18, indicated R109 was attempting to self-transfer in his room. Root-cause analysis indicated R109 should be wearing gripper socks when not wearing shoes.
- A fall on 8/3/18 indicated R109 was attempting to stand up from wheelchair in the hallway holding on to a door handle. R109 sustained a cut above his left eye and an abrasion to his left knee. A referral was made to occupational therapy to evaluate wheelchair.
- A fall on 8/28/18, indicated R109 was found on the floor in his room and had previously been woken up for toileting. Interventions included to not wake R109 for toileting.
- A fall on 9/17/18 indicated R109 was found lying on the floor in the hallway and was wearing socks only. Prior to the fall, R109 had been wandering in the hallway. Interventions included another referral to OT to evaluate wheelchair.

On 11/14/18, at 10:06 a.m. R109 was observed sitting in his wheelchair in the dining room with

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regular white socks on only. At 1:49 p.m. R109 was observed sitting at a dining room table again with regular socks on. At 2:11 p.m. R109 began wheeling himself down the hall with staff walking past him. At 2:34 p.m. R109 was observed to be sitting at the end of the hall looking out the window.

On 11/15/18, at 9:42 a.m. R109 was observed sitting in the dining room with regular socks on only.

On 11/15/18, at 1:13 p.m. registered nurse (RN)-C stated R109 liked to wander the hallways. RN-C stated for fall prevention for R109 staff would not let him eat by himself and did not lock his wheelchair.

On 11/16/18, at 8:29 a.m. R109 was observed sitting in the dining room, again with regular socks on only.

On 11/16/18, at 10:04 a.m. nursing assistant (NA)-D stated R109 liked to wheel himself to the windows and look out at the windows. NA-D verified R109 was wearing regular socks at that time. NA-D stated R109 had not fallen before on her shift and was not aware of any specific fall interventions for him including footwear or gripper socks.

On 11/16/18, at 10:20 a.m. RN-B who was the unit manager was unaware that R109 had had any falls recently and stated R109 was not a fall risk. RN-B stated he expected staff to use the same precautions as they would use for any resident such as try to anticipate their needs and

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F 689	Continued From page 39 to not keep residents in their room. A facility Fall Prevention Policy revised August 2018 was provided. It indicated that preventative measures should be taken to decrease the number of falls whenever possible.	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure comprehensive assessment of unresolved left hip pain was completed for 1 of 1 resident (R81) reviewed for reported hip pain. Findings include: R81's admission record printed on 11/14/18, indicated R81 was admitted to the facility on 6/27/18, and current diagnoses included: Parkinson disease, diabetes and peripheral vascular disease. R81's quarterly Minimum Data Set (MDS) dated 10/3/18, indicated R81 was cognitively intact. During an interview on 11/13/18, at 1:18 p.m. R81 identified "something is going on with my skin around my left hip. It feels like a rope; hard	F 697	R 81 is no longer a resident at the facility. Residents identified as having ongoing pain are discussed in morning huddle. Pain management and Change in condition policy were reviewed. Licensed staff will be re-educated on pain management. Random audits will be completed 1 time per week for 2 months and 1 time per month for 1 month. Summary of the audits will be reviewed at the QAA committee. After 3 months recommendations by the committee will be followed. DON will ensure compliance.	12/26/18

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	245587	A. BUILDING _____ B. WING _____	11/16/2018

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EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

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as a rock, so I had to have my daughter make an appointment with my own doctor to be seen." R81 further indicated she had been seen by the facility nurse practitioner (NP) and had asked to see the doctor but nobody had come. R81 further stated her hip started bothering her about two months ago.

During an interview on 11/14/18, at 8:55 a.m. R81 stated "I suffered last night in bed, my left hip was just so achy with sharp pains, and I couldn't rest." R81 indicated her left hip discomfort started "close to two months ago and the only orders the nurses got was to keep an ice pack on it, so I have asked them to put the ointment for my knees and back on it."

During an interview on 11/14/18, at 1:53 p.m. licensed practical nurse (LPN)-A stated R81 had reported the left hip pain about three to four weeks ago. LPN-A indicated R81 had reported that she had slept on a rolled up sheet which caused the pain. LPN-A identified that she called the NP and was told to apply ice and monitor the area. LPN-A revealed R81's left hip area had gotten worse and now felt hard like a mass. LPN-A stated R81 had asked to be seen by the NP, but did not think the NP had seen R81 regarding this. LPN-A reviewed R81's provider note dated 11/5/18, and verified the left hip area had not been addressed during that visit. LPN-A, with surveyor, observed the left hip area; LPN-A explained R81's left lateral hip felt warm to the touch, was hard/ firm around the area, appeared to be red and felt like a hard mass. LPN-A confirmed R81 had reported the ice was not helpful.

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On 11/14/18, at 2:11 p.m. R81 stated that her daughter had made a medical appointment with a community physician for 11/16/18, around 7:30 a.m. to have her left hip evaluated.

R81's progress notes were reviewed:
-The note dated 10/19/18, identified "resident spoke with and showed writer what looks to be a bruise, hard and painful to touch. NP was notified, NP stated ice it and monitor;"
-The note dated 11/11/18, identified voicemail was left for NP regarding hard tissue to left hip with purplish in color. "Resident stated that nurses and NP already aware of this problem and told her to apply ice packs to 2 days."
During review of R81's progress notes; the notes lacked evidence of continued assessment and/or monitoring regarding R81's left hip painful area. Furthermore, the progress notes lacked evidence of the ice ordered packs as ineffective, provider updates and R81's continued complaints of pain.

During an interview on 11/15/18, at 1:42 p.m. registered nurse (RN)-A, stated R81 had notified the nurse about a month ago and at that time the NP was updated and gave orders to apply ice and monitor. RN-A indicated on 11/11/18, the shift nurse had left the NP a voicemail regarding R81's left hip area. RN-A stated that she was unaware the NP did not respond to the 11/11/18, voicemail and had she known she would have attempted to contact the NP again. RN-A stated it was her expectation to continue to follow-up until a response was given from the NP or the doctor. RN-A further indicated she would have reached out to the medical director had the NP

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F 697	Continued From page 42 not responded timely especially since R81's hip area was not getting better. RN-A stated it was also her expectation for changes in health status to be documented in the resident progress notes. During an interview on 11/16/18, at 10:26 a.m. RN-A indicated the facility physician had seen R81 on 11/5/18, however she was not sure if the physician was aware of continued hip pain and if the NP had updated the physician. During an interview on 11/16/18, at 11:39 a.m. director of nursing (DON) stated it was her expectation for the nurse to keep calling until the provider was updated regarding a change in health status and/or a continued health concern. On 11/16/18, (on the day of survey exit) R81 was seen by a community provider for several concerns which included pain and discomfort around left hip. The provider note indicated R81 had "a myofascial tender point [muscle that causes pain]" in the left lateral buttock area; the provider administered a Kenalog (used to treat inflammation of the joint or tendon) injection. The facility policy Change of Condition Notification revised date 7/2018, included "Attending physician/ nurse practitioner, or physician on-call, is to be promptly notified of residents change in condition/ health status based on a comprehensive assessment."	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who	F 698		12/26/18

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F 698	Continued From page 43 require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the dialysis access site was monitored and assessed upon return from the dialysis treatment, for 1 of 2 residents (R59) reviewed for dialysis. Findings include: R59's admission Minimum Data Set dated 9/18/18, identified R59 had impaired cognition, required extensive assist with activities of daily living, and received dialysis. R59's admission record printed on 11/16/18, identified R59 was admitted to the facility on 10/10/18, and diagnoses included end stage renal disease (ESRD) and dependence on renal dialysis. R59's Care Area Assessment dated 9/24/18, identified R59 received dialysis however, lacked documentation of R59's fistula (intravenous access for dialysis) and did not identify any special cares related to dialysis access site. R59's order summary dated 11/30/18, included an order which was discontinued during survey on 11/15/18, and directed staff "Physical assessment of Dialysis resident: chart in progress notes any abnormal Mental Status, Lung Sounds, Respirations, Edema, Access site, Fluid restrictions, Thrill/ Bruit, left arm AV [arteriovenous] fistula. Every shift."	F 698	R59 was not harmed in this situation. Dialysis provider contacted with regards to when to change R59□s dressing. All residents participating in Dialysis were reviewed to ensure that facility care plan and dialysis care plan are integrated. Dialysis care policy was reviewed, staff will be re-educated on dialysis care. Random audits will be completed on dialysis patients 1 time per week for 2 months and 1 time per month for 1 month to ensure compliance. Summary of the audits will be reviewed at the QAA committee. After 3 months recommendations by the committee will be followed. DON will ensure compliance.	

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R59's care plan dated 10/5/18, indicated R59 was on hemodialysis due to ESRD, and interventions included: do not draw blood or take blood pressure in left arm with graft (dated 9/20/18) and monitor/ document/ report as needed signs and/or symptoms of the following: bleeding, hemorrhage, bacteremia and septic shock. R59's care plan lacked evidence of interventions for fistula monitoring, assessment and site care.

On 11/13/18, at 6:34 p.m. R59 was observed to be seated in wheelchair in her room. R59 indicated she went to dialysis on Mondays, Wednesdays and Fridays in the morning and typically returned to the facility by 12:00 p.m. R59's right arm was visible with access site covered with one dressing; that had a dried blood spot the size of a quarter in the center. R59's left arm was observed without the presence of an access site.

During an interview on 11/14/18, at 2:05 p.m. licensed practical nurse (LPN)-A confirmed R59 did have a right arm fistula and nothing on her left arm. LPN-A reviewed R59's physician orders in the electronic medical record and verified the order directed staff to assess R59's left arm and it should have directed to assess the right one. LPN-A identified the thrill/ bruit was assessed by visualization without the need to listen or feel. LPN-A indicated "we do not do anything with the dressing on her arm."

On 11/14/18, at 2:19 p.m. R59 was observed outside dining area. R59's right arm was visible

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with access site covered with two dressings and four pieces of tape. R59 stated she had been to dialysis earlier that day.

On 11/15/18, at 8:46 a.m. R59 was observed to be eating breakfast in bed. R59's right arm was visible with access site covered with two dressings and four pieces of tape. R59 stated the dressing had not been changed and was the same dressing that the dialysis nurse had placed the day prior.

During a telephone interview on 11/15/18, at 12:57 p.m. the dialysis unit registered nurse (RN)-D stated the nursing home staff was expected to monitor the fistula site daily for infections, bleeding and complications. RN-D indicated the dressing would need to be removed to complete the daily assessment of the site and that the dressing should have been removed by the facility before dinner; approximately four hours after return to facility. RN-D identified facility staff were supposed to use a stethoscope to auscultate for bruit and feel with their fingers for the thrill.

During an interview on 11/15/18, at 1:33 p.m. RN-A, also nurse manager, confirmed R59 had a right arm fistula, however R59's physician orders indicated left arm fistula. RN-A stated the staff were expected to feel for the thrill, listen for bruit and monitor the skin around the arm for swelling. RN-A indicated she was not aware of any dressing change or dressing removal orders and further stated the dressings were placed and removed at dialysis.

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F 698	Continued From page 46 During an interview on 11/16/18, at 11:36 a.m. the director of nursing (DON) stated it was her expectation that the fistula dressing would be removed following dialysis and the access site was to be assessed twice daily. The facility's Dialysis policy dated revised 8/2018, indicated "Access Assessment: Internal Accesses- Fistulas and grafts-assess dialysis site and notify dialysis unit and/ or physician timely if no thrill or bruit noted. Dressing- remove Band-Aids or gauze 4 hours after discharge from dialysis. Patency- feel the access for a thrill, listen with a stethoscope for a bruit (assess daily)."	F 698		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, develop non-pharmacological interventions and implement individualized behavior interventions for 1 of 4 resident (R9) reviewed who demonstrated physical and verbal	F 740	R9□s medication referenced was discontinued. Facility will provide non-pharmalogical intervention prior to administering medications. Interdisciplinary team will identify residents including R9 who display	12/26/18

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F 740	Continued From page 47 behaviors towards others which resulted in the administration of intramuscular (IM) injections of antipsychotic medication. Findings include: R9's diagnosis report printed 11/16/18, included schizoaffective (mental disorder) disorder bipolar (manic and depressive episodes) type, brief psychotic (impaired relationship with reality disorder and dementia without behavioral disturbances. R9's annual Minimum Data Set (MDS) dated 8/2/18, indicated R9 had cognitive impairment. The MDS indicated R9 did not present with symptoms of delusions, hallucinations, physical and/ or verbal aggression. R9's Care Area Assessment (CAA) dated 8/3/18, identified delirium, disorganized thinking and easily angered. R9's CAA indicated antipsychotic medications were administered. R9's August 2018, and November MAR was reviewed and indicated R9 had received the as needed Benadryl (antihistamine medication) 50 milligrams (mg)/Haldol (antipsychotic medication) 5 mg/Lorazepam (antianxiety medication) 2 mg; inject injection three times, on 8/23/18, on 11/14/18, and on 11/15/18. R9's progress notes were reviewed and lacked evidence and reason as to why the 8/23/18, injection was administered along with non-pharmacological interventions trialed prior to administration. The progress notes dated	F 740	behaviors that interfere with cares, participation in activities, and/or put the resident at significant risk for illness/injury. A task in Point of Care will be set up so that staff can document target behaviors. The psychopharmacologic drug use policy was reviewed, and staff re-education will be completed on behavior monitoring and side effects monitoring. We will discuss findings at morning huddle meeting. Random audits will be completed one time per week for 2 months and 1 time per month for 1 month. Summary of the audits will be reviewed at the QAA committee. After 3 months recommendations by the committee will be followed. DON will ensure compliance.	

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11/14/18, at 8: 47 p.m. indicated R9 had been "extremely agitated, verbally and physically aggressive to wards staff and the other residents on the unit. Had rapid speech, scary facial expression and tone of voice the last few days including this shift. Writer administer a combination of Haldol 1 ml [milliliter] (5 mg) along with Lorazepam 1 ml (2 mg) and Diphenhydramine (generic for Benadryl) 1 ml (50 mg) for agitation as per order which resulted in immediate calming effect on the resident. Resident currently resting quietly;" The note dated 11/15/18, at 5:00 p.m. indicated R9 "continued exhibiting agitation and aggressive behavior towards staff and residents, at times throwing punches and kicks at anybody passing by in the hallway. Writer administered a combination of Haldol 1 ml [milliliter] (5 mg) along with Lorazepam 1 ml (2 mg) and Diphenhydramine 1 ml (50 mg) IM per order to control symptoms with immediate calming effect." However there was no evidence R9's behaviors were comprehensively re-assessed in order to identify interventions to provide care's and services to improve R9's emotional and mental well-being.

R9's care plan dated 11/14/18, indicated R9 had behavior problems related to schizophrenia, bipolar with manic phases, auditory hallucinations, agitation, chronic paranoid suspicious thoughts and verbal and physical aggression towards others. R9's interventions included administer antipsychotic medication, avoid power struggles, allow resident to express feelings, approach resident in a low calm voice, be clear with expectations/ limits, discuss

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feelings with resident, encourage involvement in social activities, give as needed Ativan (antianxiety medication) for behaviors resistive to cares, restlessness, pacing, suspiciousness, preoccupied with, unsupported doubts; monitor mood and behaviors, re-approach with cares and medication as needed and update the medical provider with changes in behavior. The care plan also identified R9 as having had a life long history of mental illness with bipolar cycling. Interventions included in house psychology services as ordered and appropriate, medication treatment as ordered for management of mental health, family involvement, staff to provide cues and reassurance and support as needed to meet the resident needs. Furthermore, it was identified as a focus that R9 had taken psychotropic medication and staff were to follow non-pharmacological interventions and administer medications per provider order.

R9's order summary report dated 11/16/18, included the following psychotropic medications: Benadryl (antihistamine medication)/Haldol (antipsychotic medication)/Lorazepam (antianxiety medication); inject 1 dose IM every 6 hours as needed for schizoaffective disorder related to schizoaffective disorder bipolar type for 14 days; Lamictal (anticonvulsant medication) 150 mg every morning related to bipolar disorder; olanzapine (antipsychotic medication) 15 mg every bedtime related to bipolar disorder; Risperdal (antipsychotic medication) 1 mg every morning related to bipolar disorder, 2 mg every evening related to schizoaffective disorder, 50 mg injected every 14 days for schizoaffective and bipolar disorder and Trazodone (antidepressant

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medication) 25 mg three times daily for agitation related to schizoaffective disorder bipolar type. The order summary report lacked evidence of an order for Ativan as indicated in R9's care plan.

During an interview on 11/15/18, at 7:53 a.m. registered nurse (RN)-B identified R9 was in bed sleeping and had refused to eat breakfast due to being tired from the administration of "the B52 injection." RN-B explained the B52 was a combination of Benadryl, Haldol and Lorazepam injected IM for Bipolar with manic episodes. RN-B confirmed while reviewing R9's electronic medical record (eMAR) non-pharmacological interventions were not documented prior to medication administration. RN-B stated R9 had not been seen by in-house psychology services since 2017.

During an interview on 11/15/18, at 9:49 a.m. the facility medical director (MD) identified that he was unaware that R9 had been receiving the Benadryl, Haldol and Lorazepam injections. MD identified the "triple combo" was uncommon and he had not seen this used often especially as an injectable. MD stated it was his expectation for non-pharmacological interventions to be trialed first prior to any as needed psychotropic medication administration. MD indicated the in-house psychology services would also evaluate the resident and make recommendations about mood and behavior interventions.

On 11/16/18, at 8:25 a.m. R9 was laying in her bed stated she had slept well and explained she had received medicine "a shot" as she pointed to her right arm "last night; I cried." R9 was unable

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to discuss specifics regarding why the medication had been administered.

During interview on 11/16/18, at 8:29 a.m. RN-F identified R9 has cycles of manic episodes but will calm down when offered 1 to 1 time, pop and talking to her. RN-F further explained that in the past oral Lorazepam was effective for R9 and she did not need the IM injection of Benadryl, Haldol and Lorazepam. Furthermore, RN-F indicated the oral Lorazepam should be tried first along with other non-pharmacological interventions and if those did not work then go to the IM injection. RN-F reviewed R9's current physician orders and stated R9 did not have an order for oral Lorazepam.

During a telephone interview on 11/16/18, at 10:01 a.m. the facility pharmacist consultant stated it was her expectation the staff would clarify orders when an as needed medication order is written without clear clinical indication and/ or when to give one medication versus another. She also indicated non-pharmacological interventions should be trialed and documented with effectiveness prior to any as needed psychotropic medication administration.

During an interview on 11/16/18, at 11:11 a.m. with both the director of nursing (DON) and RN-B; the DON stated the order from 11/14/18, should have been clarified by the provider prior to administration. RN-B stated since they had administered the medication in the past they used the same diagnosis. The DON also stated the order from 8/23/18, should have been clarified with parameters for when to give the oral

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F 740	Continued From page 52 Lorazepam and when to go to the injection of Benadryl/ Haldol and Lorazepam. Furthermore, the DON stated the IM injection should only be used as a last resort when all other non-pharmacological interventions have failed. The facility policy Psychopharmacologic Drug Use revision date 9/2018, indicated "9 ...medication is not the sole approach for behavioral interventions ...11. As needed (PRN) orders must include an indication for use. a. If the PRN medication will be used to modify behavior, the indication(s) for use must be clearly defined in objective terms, e.g., what specific symptom(s) is being addressed."	F 740		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		12/26/18

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F 758	Continued From page 53 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to adequately monitor the effectiveness of psychotropic medications and failed to ensure an administered as needed antipsychotic (medication used to treat psychotic disorders) medication had adequate clinical indication for administration for 2 of 6 residents (R10, R9) reviewed who used psychotropic	F 758	R9 and R10□s medications referenced were discontinued. Facility will provide non-pharmalogical intervention prior to administering medications. Interdisciplinary team will identify residents including R9 and R10 who display behaviors that interfere with cares, participation in activities, and/or put the	

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F 758	Continued From page 54 medications. Findings include: R10's diagnosis report printed on 11/16/18, indicated R10 had diagnoses which included dementia without behavioral disturbances, generalized anxiety disorder and adjustment disorder with mixed disturbance of emotions and conduct. R10's Care Area Assessment (CAA) dated 2/6/18, identified R10 to have had perceptual disturbances such as hallucinations and delusions and delirium. R10's CAA indicated antianxiety medication were administered. R10's care plan dated 11/14/18, indicated for staff to administer psychotropic medications as ordered and to monitor and document effectiveness. R10's physician orders printed on 11/16/18, indicated Depakote (mood stabilizer) 500 milligrams (mg) two times daily for agitation and mood with order date 4/5/18, and Seroquel (antipsychotic medication) 25 mg two times daily for dementia with psychosis with order date 10/9/18. R10's October and November 2018, medication administration record and treatment administration records were reviewed and lacked evidence of behavior monitoring. R10's September, October and November 2018, progress notes were reviewed and lacked evidence of behavior monitoring.	F 758	resident at significant risk for illness/injury. A task in Point of Care will be set up so that staff can document target behaviors. The psychopharmacologic drug use policy was reviewed, and staff re-education will be completed on behavior monitoring and side effects monitoring. Findings will be discussed at morning huddle meeting. Random audits will be completed one time per week for 2 months and 1 time per month for 1 month. Summary of the audits will be reviewed at the QAA committee. After 3 months recommendations by the committee will be followed. DON will ensure compliance.	

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On 11/15/18, at 2:56 p.m. R10 was sitting in dining room watching television. R10 was able to return greeting but was not able to discuss what medications he was taking.

During an interview on 11/15/18, at 8:10 a.m. registered nurse (RN)-B, also nurse manager, verified R10 did not have any behavior monitoring since 3/3/18. RN-B stated R10 did not having any as needed psychotropic medications ordered; so the behaviors monitoring was not needed.

During an interview on 11/16/18, 11:29 a.m. the director of nursing (DON) stated R10 should have been monitored daily every shift for his target behaviors related to the Depakote and Seroquel. The DON also stated it was her expectation to monitor a resident's target behaviors for a prescribed medication every shift and document this on the treatment administration record.

During a telephone interview on 11/16/18, at 10:01 a.m. the facility consultant pharmacist stated it was her expectation to for a resident on a scheduled antipsychotic medication to have had routine behavior monitoring per facility policy.

The facility policy Psychopharmacologic Drug Use revision date 9/ 2018, indicated "9. Nursing services, social services and other members of the interdisciplinary team will address the behavior in progress notes; care plans on the NAR [nursing assistant] care sheets/ kardex, on treatment/ medication sheets or other forms per facility behavior monitoring programs."

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R9
R9's diagnosis report printed 11/16/18, included schizoaffective (mental disorder) disorder bipolar (manic and depressive episodes) type, brief psychotic (impaired relationship with reality disorder and dementia without behavioral disturbances.

R9's annual Minimum Data Set (MDS) dated 8/2/18, indicated R9 had cognitive impairment. The MDS indicated R9 did not present with symptoms of delusions, hallucinations, physical and/ or verbal aggression. R9's Care Area Assessment (CAA) dated 8/3/18, identified delirium, disorganized thinking and easily angered. R9's CAA indicated antipsychotic medications were administered.

R9's care plan dated 11/14/18, indicated R9 had taken psychotropic medication and staff were to follow non-pharmacological interventions and administer medications per provider order.

R9's order summary report dated 11/16/18, included the following psychotropic medications: Benadryl (antihistamine medication)/Haldol (antipsychotic medication)/Lorazepam (antianxiety medication); inject 1 dose IM every 6 hours as needed for schizoaffective disorder related to schizoaffective disorder bipolar type for 14 days; Lamictal (anticonvulsant medication) 150 mg every morning related to bipolar disorder; olanzapine (antipsychotic medication) 15 mg every bedtime related to bipolar disorder; Risperdal (antipsychotic medication) 1 mg every morning related to bipolar disorder, 2 mg every

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evening related to schizoaffective disorder, 50 mg injected every 14 days for schizoaffective and bipolar disorder and Trazodone (antidepressant medication) 25 mg three times daily for agitation related to schizoaffective disorder bipolar type. R9's physician order dated 11/14/18, indicated "Lorazepam 2 mg/ ml solution for IM injection; Draw up 2 mg along with 5 mg Haldol and 50 mg Benadryl and give IM every 6 hours as needed for 14 days; dispense 40 ml;" However, the order lacked clinical indication as to why the medication was to be administered.

R9's November 2018, medication administration record (MAR) was reviewed and included as needed Benadryl (antihistamine medication) 50 milligrams (mg)/ Haldol (antipsychotic medication) 5 mg/ Lorazepam (antianxiety medication) 2 mg; inject 1 dose intramuscularly (IM) every 6 hours as needed for schizoaffective disorder related to schizoaffective disorder bipolar type for 14 days. R9's MAR revealed the medication had been administered on 11/14/18, at 8:40 p.m. and 11/15/18, at 4:57 p.m. both were documented to have had an effective result. November 2018, treatment administration record (TAR) was reviewed and included target behavior monitoring "A) resistive to cares; B) refuses to eat; C) refuses to take medications; D) excessive pacing; E) anxious; F) paranoid thoughts; G) talking to her-self excessively; H) refusing cares; I) isolation; J) Auditory hallucinations; K) agitation; L) False allegations; M) verbal and physical aggression towards others; N) inappropriate touch of others; O) Will void in inappropriate areas; P) disruption of others environment; and Q) None. The TAR directed the

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staff to document regarding R9's behaviors every shift; on 11/14/18, during the evening shift documentation "None" was documented. On 11/15/18, during the evening shift "Q" was documented.

R9's progress notes were reviewed the note dated 11/14/18, at 8: 47 p.m. indicated R9 had been "Extremely agitated, verbally and physically aggressive to wards staff and the other residents on the unit. Had rapid speech, scary facial expression and tone of voice the last few days including this shift. Writer administer a combination of Haldol 1 ml [milliliter] (5 mg) along with Lorazepam 1 ml (2 mg) and Diphenhydramine (generic for Benadryl) 1 ml (50 mg) for agitation as per order which resulted in immediate calming effect on the resident. Resident currently resting quietly;" The note dated 11/15/18, at 5:00 p.m. indicated R9 "continued exhibiting agitation and aggressive behavior towards staff and residents, at times throwing punches and kicks at anybody passing by in the hallway. Writer administered a combination of Haldol 1 ml [milliliter] (5 mg) along with Lorazepam 1 ml (2 mg) and Diphenhydramine 1 ml (50 mg) IM per order to control symptoms with immediate calming effect." There was no indication of non-pharmacological approaches tried prior to administering PRN injection.

During an interview on 11/15/18, at 7:53 a.m. registered nurse (RN)-B identified R9 was in bed sleeping and had refused to eat breakfast due to being tired from the administration of "the B52 injection." RN-B explained the B52 was a

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combination of Benadryl, Haldol and Lorazepam injected IM for Bipolar with manic episodes.

On 11/16/18, at 8:25 a.m. R9 was observed laying in her bed stated she had slept well and explained she had received medicine "a shot" as she pointed to her right arm "last night, I cried." R9 was unable to discuss any further details regarding her medications.

During interview on 11/16/18, at 8:29 a.m. RN-F identified R9 had cycles of manic episodes but would calm down when offered 1 to 1 time, pop and talking to her. RN-F further explained that in the past oral Lorazepam was effective for R9 and she did not need the IM injection of Benadryl, Haldol and Lorazepam. Furthermore, RN-F indicated the oral Lorazepam should be tried if that did not work then go to the IM injection. RN-F reviewed R9's current physician orders and stated R9 did not have an order for oral Lorazepam.

During a telephone interview on 11/16/18, at 10:01 a.m. the facility pharmacist consultant stated it was her expectation the staff would clarify orders when an as needed medication order was written without clear clinical indication and/ or when to give one medication versus another.

During an interview on 11/16/18, at 11:11 a.m. with both the director of nursing (DON) and RN-B; the DON stated the order from 11/14/18, should have been clarified by the provider prior to administration. RN-B stated since they had administered the medication in the past they

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F 758	Continued From page 60 used the same diagnosis for the current order as well. The DON further stated it was her expectation that clinical indications for medications be obtained directly from the prescribing provider. Initial call placed to the nurse practitioner (NP) on 11/16/18, at 9:3 a.m.; and voicemail left requested a return call. During a return call telephone interview on 11/19/18, at 1:12 p.m. the NP stated "we ordered the B52 because R9 wasn't taking any of her pills ...we usually just use the B52 when she's refusing her medications." The NP further identified R9 had also been striking at staff and generally being physically aggressive and that the staff were aware why the medication had been ordered. The NP was unable to recall if ordering oral Ativan had been discussed during the month of November, however the NP stated "they didn't say we need something PRN [as needed] they only asked for the injection again." The facility policy Psychopharmacologic Drug Use revision date 9/2018, indicated "9 ...medication is not the sole approach for behavioral interventions ...11. As needed (PRN) orders must include an indication for use. a. If the PRN medication will be used to modify behavior, the indication(s) for use must be clearly defined in objective terms, e.g., what specific symptom(s) is being addressed."	F 758		
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	F 880		12/26/18

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infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention 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:

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F 880	Continued From page 62 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed 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 interview and document review, the facility failed to ensure consistent and comprehensive monthly surveillance data was tracked to identify trends and patterns to reduce the spread of illness and infection. This had the potential to affect all 120 residents residing in the facility, staff and visitors. Findings include:	F 880	The infection control log has been reviewed and revised so that it is updated with pertinent information. Reviewed the antibiotic use policy, re-education to be completed with nurse managers, and staff educator. Random audits will be completed weekly for 3 months to ensure the infection control tracking log is complete with all	

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F 880	Continued From page 63 The August 2018, Infection Control (IC) log identified 13 residents in the facility with: 1 urinary tract infection (UTI), 3 respiratory, 1 prophylactic, 1 bone infection, 2 surgical post-operative care, 1 clostridium difficile, 1 skin and 3 other. The column labeled "culture done chest x-ray done" was blank for 12 of the 13 residents. The column labeled "organism present (if known)" was blank for 13 of 13 residents. The IC log also lacked evidence of illness tracking when signs and symptoms were present without a prescribed antibiotic. The September 2018, IC log identified 18 residents in the facility with: 4 UTIs, 2 tooth infections, 7 skin, 1 pneumonia, 1 clostridium difficile and 1 other. However, the IC log lacked evidence of illness tracking when signs and symptoms were present without a prescribed antibiotic. The October 2018, IC log identified 17 residents in the facility with 7 cellulitis/ skin infections, 3 UTI, 1 neutropenia, 1 eye pain, 1 throat, 1 prophylaxis, 1 upper respiratory infection, 1 pneumonia and 1 conjunctivitis. The column labeled "date and symptoms noted" listed only the date of onset and lacked evidence of symptoms associated with the diagnosed illness for 17 of 17 residents. The column labeled "antibiotic use appropriate" was blank for 17 of 17 residents. The IC log also lacked evidence of illness tracking when signs and symptoms were present without a prescribed antibiotic. The November 2018, IC log identified 5 residents	F 880	necessary information and monitored accordingly. Summary of the audits will be reviewed at the QAA committee. After 3 months recommendations by the committee will be followed. DON will ensure compliance.	

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in the facility with 1 sepsis, 2 wound infections, 1 UTI and 1 cellulitis. The column labeled "date and symptoms noted" listed only the date of onset and lacked evidence of symptoms associated with diagnosed illness for 5 of 5 residents. The column labeled "antibiotic use appropriate" was blank for 4 of 5 residents. The IC log also lacked evidence of illness tacking when signs and symptoms were present without a prescribed antibiotic.

During an interview on 11/15/18, at 1:02 p.m. the Infection Preventionist (IP) identified the facility had been tracking and monitoring only residents who were being actively treated with antibiotics. IP indicated both November and October 2018, IC logs did not have listed illness symptoms related to the infection and this could be found in the nursing progress notes. IP stated both November and October 2018, IC log did not address if the antibiotic use was appropriate, however stated all nursing staff had been trained to utilize Lobes criteria. The IP confirmed September 2018, IC log did not track and trend signs and symptoms when present without a prescribed antibiotic. The IP verified August 2018, did not include identified organisms.

During an interview on 11/16/18, at 11:43 a.m. the director of nursing (DON) stated it was her expectation that every illness regardless of antibiotic indication should be tracked and trended in addition to confirmed infections. The DON further indicated it was her expectation that organisms be identified and tracked along with antibiotic appropriateness.

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	245587	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 65 The facility policy Antibiotic Stewardship Program effective date 9/2018, indicated " ...the facility has developed an antibiotic stewardship program that will review the use of antibiotic appropriateness." The facility policy Infection Surveillance effective date 11/2018, indicated " ...the purpose of monitoring practices that help with the promotion of a safe and sanitary environment and help prevent the development and transmission of infection."	F 880		
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 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	F 883		12/26/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 66 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 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 1 of 5 resident (R18) reviewed were offered and provided pneumococcal conjugate vaccine (PCV 13). Findings include:	F 883	R18 received his Pneumococcal vaccination. Resident pneumococcal vaccine policy reviewed. Staff will be re-educated on pneumococcal vaccinations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 67 The current guidelines by the Center for Disease Control and Prevention (CDC) recommended the pneumococcal polysaccharide vaccine (PPSV23) and PCV13 for all adults 65 years or older. It recommended, for those age 65 or older to administer PPSV23 at least 1 year after PCV13. It further recommended if an individual received a dose of the PPSV23 before age 65, they should receive another dose of the PPSV23 after age 65. R18's face sheet indicated R18 was 76 years old. R18 admitted to the facility on 9/10/2018. On 11/15/18, at 2:01 p.m. review of R18's immunization report identified R59's most recent PPSV23 was given in 2011 and there was no record of PCV13. However, R18's immunization report printed on 11/16/18, indicated no record of PPSV23 and that R59 had refused PCV13. During an interview on 11/16/18, at 10:35 a.m. registered nurse (RN)-A, also nurse manger, stated she had spoken with R18 on 11/15/18 (after survey began), and R18 had refused her PCV13 at that time. RN-A confirmed R18 had received the PPSV23 prior to admission to the facility. RN-A verified R18 should have gotten the PCV 13 upon admission. RN-A identified she relied on the facility pharmacy consultant and/ or the nurse practitioner to indicate when a resident was in need of an immunization and further stated there was not a process in place for checking resident vaccination status. During an interview on 11/16/18, at 11:43 a.m. director of nursing (DON) stated it was her	F 883	A facility wide audit was completed and any resident who did not have a pneumococcal vaccination on record will be offered the vaccination. An audit on new admissions will be completed for 3 months. Summary of the audits will be reviewed at the QAA committee. After 3 months recommendations by the committee will be followed. DON will ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 68 expectation for immunizations to be offered upon admission to the facility. The DON indicated she planned to get the facility staff access to the Minnesota Immunization Information Connection (MIIC) system in the future. The facility policy Resident Pneumococcal Vaccine revised date 10/2018, indicated received PPSV23 at age 65 or older: wait one year before giving PCV13. Received PCV13 and maybe PPSV23 before age 65 administer PPSV23 at least 8 weeks later after PCV13, wait 5 years between PPSV23 doses.	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	**2545 PORTLAND AVENUE SOUTH** **MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 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. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on November 21, 2018. At the time of this survey, Ebenezer Care center Building 01 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. 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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/14/2018

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
	245587	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	**2545 PORTLAND AVENUE SOUTH** **MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 IS NOT REQUIRED.	K 000		

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

By email to:
FM.HC.Inspections@state.mn.us

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

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

2. The actual, or proposed, completion date.

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

Ebenezer Care Center is a 3-story building with a full basement. The building was constructed at 4 different times. The original building was constructed in 1919 and was determined to be of Type III(200) construction. In 1924, an addition was constructed to the North side of the building that was determined to be of Type III(200) construction. In 1928, another addition was constructed to the South side of the building that was determined to be of Type III(200) construction. In 1952, a 3-story addition of Type 1(332) construction was added. The 1952 addition was surveyed as a separate building. This facility is fully protected throughout by an automatic fire sprinkler system and has a complete fire alarm system with smoke detection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	**2545 PORTLAND AVENUE SOUTH** **MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a capacity of 127 beds and had a census of 119 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 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 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111)	K 161		12/26/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	**2545 PORTLAND AVENUE SOUTH** **MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 161	Continued From page 3 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, this building does not meet the requirement for construction type and height in accordance with the 2012 LSC (NFPA 101). 19.1.6.1. This deficient practice could affect all 119 residents. Findings include: On a facility tour at 12:09 PM on November 21, 2018, observation revealed that the facility is a 3-story building of Type III(200) construction. This type of construction is not allowed for a building of this height. This deficient practice was verified by the Maintenance Director at the time of discovery.	K 161	on 12/12/18 the time limited waiver was requested per S&C: 17-15-LSC."	
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges,	K 211		12/26/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 211	Continued From page 4 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 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not maintain a continuous means of egress that was free from obstructions. NFPA 101 (2012) 19.2.2, 19.2.11, 19.2.1, 7.1.10.1. This deficient practice could effect all 119 residents. Findings include: On a facility tour at 12: 39 PM on November 21, 2018, observation revealed that the first floor exit stairwell doors in building 1, swing into the egress corridor. This deficient practice was verified by the Maintenance Director at the time of discovery.	K 211	On 12/12/18 the time limited waiver was requested per S&C: 17-15-LSC.	
K 233 SS=F	Clear Width of Exit and Exit Access Doors CFR(s): NFPA 101 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 This REQUIREMENT is not met as evidenced by:	K 233		12/26/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	**2545 PORTLAND AVENUE SOUTH** **MINNEAPOLIS, MN 55404**

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K 233	Continued From page 5 Based on observation and staff interview, the facility failed to maintain 32 inches of clear width in exit access doors and exit doors. NFPA 101 (2012) 19.2.3.6, 19.2.3.7. This deficient practice could effect all 119 residents. Findings include: On a facility tour at 12:27 on November 21, 2018, observation revealed that the doors in building 1 were found to be only 29-30 inches in clear width. This does not meet the 32-inch requirement for existing exit access doors where bed or wheelchair bound residents are required to be evacuated. This deficient practice was verified by the Maintenance Director at the time of discovery.	K 233	On 12/12/18 the time limited waiver was requested per S&C: 17-15-LSC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING 02 - BLDG TWO B. WING _____	11/21/2018

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on November 21, 2018. At the time of this survey, Ebenezer Care Center Building 02 was found 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Ebenezer Care Center Building 2 is a 3-story building with a full basement. The building was constructed in 1952 and was determined to be of Type I(332) construction. The building is fully protected throughout by an automatic fire sprinkler system and 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 127 beds and had a census of 119 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/14/2018

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.

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 K161 Building does not meet construction type and height requirements of NFPA 101(12), Sec. 19.1.6.1	In accordance with S&C: 17-15-LSC, a time-limited waiver is requested for K161 until 06/30/2021 for the following reasons: A. A waiver is made necessary in this case because the building no longer achieves a passing FSES score. This is due to an increase in the mandatory minimum score required for "Extinguishment (Sb)" on FSES Worksheet 4.7.8B – Form CMS-2786T (10/2016). As shown in the worksheets from an FSES evaluation conducted on 12/06/18 & 12/07/18, only the 3rd Floor fails to achieve a passing score on the FSES and then only in the category Extinguishment Safety (S_2) – see Worksheet 4.7.9. B. The specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility because: 1. To meet the requirements of NFPA 101(12), Sec. 19.1.6.1 for a 3-story building, the building construction type would have to be upgraded from Type III(200) to at least Type II(111). This is not economically feasible as it would require that the building be completely vacated and the interior of the building demolished – i.e. the wood roof, floors and structural members would have to be removed and replaced with noncombustible construction (e.g. concrete and steel). That is assuming the existing exterior bearing walls could carry the additional weight of the newly installed concrete and steel. 2. It has been determined that the best way to completely correct the noncompliance would be to construct a new facility. While a site has been selected for the new building, construction cannot begin until an exception has been granted from the moratorium the State of Minnesota has in effect on the construction of new nursing homes. The State of Minnesota reviews applications for moratorium exceptions only at certain times of the year. As a result, the application, review and approval process for a moratorium exception can take up to a year to complete. A moratorium exception to construct a new building is expected to be received by February 28, 2019. 3. A guaranteed maximum price will be agreed upon with the general contractor by November 30, 2018. 4. Ebenezer Care Center will be submitting our application for a moratorium exception replacement and upgrade project on 12/19/2018 and the estimated total cost for the project is $33,169,216. 5. The Ebenezer Board of Directors has approved this project. After the project is approved by MDH, Ebenezer will secure funding, including a fundraising campaign. 6. An architect has been engaged to prepare the necessary construction documents. The estimated construction commencement is spring 2020. 7. The completed construction documents will be submitted to the MN Department of Health Engineering Services and the City of Minneapolis for review and approval and necessary permits. The necessary approvals and permits and estimated construction commencement is Spring 2020.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* Thomas Linhoff 12424	Title Fire Safety Supervisor	Office MN State Fire Marshal	Date 12-18-18

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 K161 Building does not meet construction type and height requirements of NFPA 101(12), Sec. 19.1.6.1	In accordance with S&C: 17-15-LSC, a time-limited waiver is requested for K161 until 06/30/2021 for the following reasons (continued): B. The specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility because (continued): 8. Phased construction is expected to commence Spring 2020 and all phases expected to be completed by April 30, 2021. 9. Upon completion of construction, an inspection by MN Department of Health Engineering Services, MN State Fire Marshal and City of Minneapolis will be scheduled to ensure compliance with all applicable code requirements. These inspections are expected to be done and a Certificate of Occupancy issued by May 31, 2021. 10. The residents will be relocated from Ebenezer Care Center Building 01 at the commencement of the replacement project in spring 2020. Relocation back to the new facility is expected to be completed by 06/30/2021. C. The waiver would not adversely affect the health and safety of the residents, visitors and staff because: 1. The building is protected throughout by a wet-pipe automatic fire sprinkler system consisting of quick-response sprinklers that is installed in conformance with NFPA 13 and maintained in accordance with NFPA 25. 2. The building fire alarm system is monitored to provide automatic notification to the Minneapolis Fire Department, which is a full-time department. There is a fire station within approximately 11 blocks of the facility. 3. Electrically supervised automatic smoke detection is provided in the corridors and spaces open to the corridors. 4. The smoke compartments on 2nd and 3rd Floors range from approximately 3,225 ft^2 to approximately 5,225 ft^2 in size, which is far below the 22,500 ft^2 allowed by NFPA 101(12), Sec. 19.3.7.1(1). 5. The maximum travel distance from any point in the smoke compartments on 2nd and 3rd Floors to reach a smoke barrier door is not more than 115 ft, which is less than the maximum 200 ft travel distance specified in NFPA 101(12), Sec. 19.19.3.7.1(1). 6. As shown on the enclosed FSES worksheets – Form CMS-2786T (10/2016): a. The basement level and 1st and 2nd Floors of the building achieve a passing FSES score. b. The 3rd Floor achieves a passing score in all individual safety evaluations in Worksheet 4.7.9 except "Extinguishment Safety (S2)". This is a result of an increase in the mandatory minimum score required for "Extinguishment (Sb)" on Worksheet 4.7.8B of the FSES worksheets.

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

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 K211 Swing of 1st Floor exit stairwell doors does not meet NFPA 101(12), Sec. 19.2.1 & 19.2.2	In accordance with S&C: 17-15-LSC, a time-limited waiver is requested for K211 until 06/30/2021 for the following reasons: A. A waiver is made necessary in this case because the building no longer achieves a passing FSES score. This is due to an increase in the mandatory minimum score required for "Extinguishment (Sb)" on FSES Worksheet 4.7.8B – Form CMS-2786T (10/2016). As shown in the worksheets from an FSES evaluation conducted on 12/06/18 & 12/07/18, only the 3rd Floor fails to achieve a passing score on the FSES and then only in the category Extinguishment Safety (S_2) – see Worksheet 4.7.9. B. The specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility because: 1. NFPA 101(12), Sec. 4.6.5 allows the authority having jurisdiction to modify the requirements of the Code for existing buildings in cases where their application would be impractical, so long as a reasonable level of safety is provided. The noncompliant swing of the exit stairwell doors was factored into the worksheets from the 12/06/18 & 12/07/18 FSES evaluation. In spite of this condition, the worksheets show that the 1st Floor still achieves a passing score – see Worksheets 4.7.6 and 4.7.9. Changing the 1st Floor exit stairwell doors to swing into the stairwell instead of into the corridor to correct the K211 deficiency would create another deficiency, because the doors, during their swing, would obstruct more than half of the width of the stairwell landings. This would be a violation of NFPA 101(12), Sec. 7.2.1.4.3.1. As a result, correction of the deficient condition cited in K211 would require a complete reconstruction of the exit stairwells and adjacent corridors. To accomplish this, portions of the building would need to be vacated for extended periods of time resulting in the displacement of residents. Even then, the building would still not achieve a passing FSES score because of a building construction type (K161) deficiency cited during the same survey. 2. Ebenezer Care Center has determined that the best way to completely correct the noncompliance cited in data tags K211 and K161 would be to construct a new facility. While a site has been selected for the new building, construction cannot begin until an exception has been granted from the moratorium the State of Minnesota has in effect on the construction of new nursing homes. The State of Minnesota reviews applications for moratorium exceptions only at certain times of the year. As a result, the application, review and approval process for a moratorium exception can take up to a year to complete. A moratorium exception to construct a new building is expected to be received by February 28, 2019. 3. Ebenezer Care Center will be submitting our application for a moratorium exception replacement and upgrade project on 12/19/2018 and the estimated total cost for the project is $33,169,216. 4. The Ebenezer Board of Directors has approved this project. After the project is approved by MDH, Ebenezer will secure funding, including a fundraising campaign. 5. An architect has been engaged to prepare the necessary construction documents. The estimated construction commencement is spring 2020.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date
Thomas Linhoff 12424	Fire Safety Supervisor	MN State Fire Marshal	12-18-18

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 K211 Swing of 1st Floor exit stairwell doors does not meet NFPA 101(12), Sec. 19.2.1 & 19.2.2	In accordance with S&C: 17-15-LSC, a time-limited waiver is requested for K211 until 06/30/2021 for the following reasons (continued): B. The specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility because (continued): 6. The completed construction documents will be submitted to the MN Department of Health Engineering Services and the City of Minneapolis for review and approval and necessary permits. The necessary approvals and permits and estimated construction commencement is Spring 2020. 7. Phased construction is expected to commence Spring 2020 and all phases expected to be completed by April 30, 2021. 8. Upon completion of construction, an inspection by MN Department of Health Engineering Services, MN State Fire Marshal and City of Minneapolis will be scheduled to ensure compliance with all applicable code requirements. These inspections are expected to be done and a Certificate of Occupancy issued by May 31, 2021. 9. The residents will be relocated from Ebenezer Care Center Building 01 at the commencement of the replacement project in spring 2020. Relocation back to the new facility is expected to be completed by 06/30/2021. C. The waiver would not adversely affect the health and safety of the residents, visitors and staff because: 1. The building is protected throughout by a wet-pipe automatic fire sprinkler system consisting of quick-response sprinklers that is installed in conformance with NFPA 13 and maintained in accordance with NFPA 25. 2. The building fire alarm system is monitored to provide automatic notification to the Minneapolis Fire Department, which is a full-time department. There is a fire station within approximately 11 blocks of the facility. 3. Electrically supervised automatic smoke detection is provided in the corridors and spaces open to the corridors. 4. The smoke compartments on 2nd and 3rd Floors range from approximately 3,225 ft^2 to approximately 5,225 ft^2 in size, which is far below the 22,500 ft^2 allowed by NFPA 101(12), Sec. 19.3.7.1(1). 5. As shown on the enclosed FSES worksheets – Form CMS-2786T (10/2016): a. The basement level and 1st and 2nd Floors of the building achieve a passing FSES score. b. The 3rd Floor achieves a passing score in all individual safety evaluations in Worksheet 4.7.9 except "Extinguishment Safety (S2)". This is a result of an increase in the mandatory minimum score required for "Extinguishment (Sb)" on Worksheet 4.7.8B of the FSES worksheets.

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

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 K233 Exit access door width does not meet NFPA 101(12), Sec. 19.2.3.6	In accordance with S&C: 17-15-LSC, a time-limited waiver is requested for K233 until 06/30/2021 for the following reasons: A. A waiver is made necessary in this case because the building no longer achieves a passing FSES score. This is due to an increase in the mandatory minimum score required for "Extinguishment (Sb)" on FSES Worksheet 4.7.8B – Form CMS-2786T (10/2016). As shown in the worksheets from an FSES evaluation conducted on 12/06/18 & 12/07/18, only the 3rd Floor fails to achieve a passing score on the FSES and then only in the category Extinguishment Safety (S_2) – see Worksheet 4.7.9. B. The specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility because: 1. NFPA 101(12), Sec. 4.6.5 allows the authority having jurisdiction to modify the requirements of the Code for existing buildings in cases where their application would be impractical, so long as a reasonable level of safety is provided. The noncompliant width of the facility's corridor doors was factored into the worksheets from the 12/06/18 & 12/07/18 FSES evaluation. In spite of this condition, the worksheets show that the basement level and 1st and 2nd Floors still achieve a passing FSES score and the 3rd Floor achieves a passing score in the categories of Containment Safety (S_1), People Movement Safety (S_3) and General Safety (S_4) – see Worksheets 4.7.6 and 4.7.9. 2. The facility feels that the correction of this deficiency would cause the need for disproportionate effort, expense and disruption of services with little or no increase in life safety. The cost of widening the doors in the means of egress to meet the minimum requirements of the code is estimated at over $950,000. The facility only allows the use of wheelchairs that fit through the building's existing door openings to ensure that residents have full freedom of movement throughout the facility. Ebenezer Care Center does not evacuate by bed. Should it become necessary, residents would instead be evacuated by being transferred to a wheelchair or by means of a blanket drag or 2-person carry. The facility feels this meets the intent of NFPA 101(12), Sec. 19.2.3.7((2). 3. Even if the facility were to go through the expense of widening the means of egress doors, the building would still not achieve a passing FSES score because of a building construction type (K161) deficiency cited during the same survey. Ebenezer Care Center has determined that the best way to completely correct the noncompliance cited in data tags K233 and K161 would be to construct a new facility. While a site has been selected for the new building, construction cannot begin until an exception has been granted from the moratorium the State of Minnesota has in effect on the construction of new nursing homes. The State of Minnesota reviews applications for moratorium exceptions only at certain times of the year. As a result, the application, review and approval process for a moratorium exception can take up to a year to complete. A moratorium exception to construct a new building is expected to be received by February 28, 2019. 4. Ebenezer Care Center will be submitting our application for a moratorium exception replacement and upgrade project on 12/19/2018 and the estimated total cost for the project is $33,169,216. 5. The Ebenezer Board of Directors has approved this project. After the project is approved by MDH, Ebenezer will secure funding, including a fundraising campaign. 6. An architect has been engaged to prepare the necessary construction documents. The estimated construction commencement is spring 2020. 7. The completed construction documents will be submitted to the MN Department of Health Engineering Services and the City of Minneapolis for review and approval and necessary permits. The necessary approvals and permits and estimated construction commencement is Spring 2020.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* Thomas Linhoff 12424	Title Fire Safety Supervisor	Office MN State Fire Marshal	Date 12-18-18

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 K233 Exit access door width does not meet NFPA 101(12), Sec. 19.2.3.6	In accordance with S&C: 17-15-LSC, a time-limited waiver is requested for K233 until 06/30/2021 for the following reasons (continued): B. The specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility because (continued): 8. Phased construction is expected to commence Spring 2020 and all phases expected to be completed by April 30, 2021. 9. Upon completion of construction, an inspection by MN Department of Health Engineering Services, MN State Fire Marshal and City of Minneapolis will be scheduled to ensure compliance with all applicable code requirements. These inspections are expected to be done and a Certificate of Occupancy issued by May 31, 2021. 10. The residents will be relocated from Ebenezer Care Center Building 01 at the commencement of the replacement project in spring 2020. Relocation back to the new facility is expected to be completed by 06/30/2021. C. The waiver would not adversely affect the health and safety of the residents, visitors and staff because: 1. The building is protected throughout by a wet-pipe automatic fire sprinkler system consisting of quick-response sprinklers that is installed in conformance with NFPA 13 and maintained in accordance with NFPA 25. 2. The building fire alarm system is monitored to provide automatic notification to the Minneapolis Fire Department, which is a full-time department. There is a fire station within approximately 11 blocks of the facility. 3. Electrically supervised automatic smoke detection is provided in the corridors and spaces open to the corridors. 4. The smoke compartments on 2nd and 3rd Floors range from approximately 3,225 ft^2 to approximately 5,225 ft^2 in size, which is far below the 22,500 ft^2 allowed by NFPA 101(12), Sec. 19.3.7.1(1). 5. The maximum travel distance from any point in the smoke compartments on 2nd and 3rd Floors to reach a smoke barrier door is not more than 115 ft, which is less than the maximum 200 ft travel distance specified in NFPA 101(12), Sec. 19.19.3.7.1(1). 6. As shown on the enclosed FSES worksheets – Form CMS-2786T (10/2016): a. The basement level and 1st and 2nd Floors of the building achieve a passing FSES score. b. The 3rd Floor achieves a passing score in all individual safety evaluations in Worksheet 4.7.9 except "Extinguishment Safety (S2)". This is a result of an increase in the mandatory minimum score required for "Extinguishment (Sb)" on Worksheet 4.7.8B of the FSES worksheets.

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

Report of Consultant FSES Findings

Ebenezer Care Center

2545 Portland Avenue South

Minneapolis, MN 55404

Provider No. 245587

Date of Survey: December 06 & 07, 2018

Prepared by:
Robert L. Imholte, President
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December 10, 2018

Christina Cauble
Administrator
Ebenezer Care Center
2545 Portland Avenue South
Minneapolis, Minnesota 55404

RE: FSES at Ebenezer Care Center

Dear Ms. Cauble:

Enclosed please find the survey information relating to the fire safety evaluation of Ebenezer Care Center, 2545 Portland Avenue South in Minneapolis conducted on 12/06/2018. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(2013), *Guide on Alternative Approaches to Life Safety*. As you're aware, the FSES is a rating system designed to evaluate the level of fire/life safety in health care facilities and serves as a method to demonstrate alternative compliance with the 2012 edition of the *Life Safety Code*® (NFPA 101). An FSES was made necessary in this case because of deficiencies cited against the facility relating to:

- Construction type and height (K161),
- Stairway door swing (K211), and
- Resident room door width (K233).

Ebenezer Care Center consists of two buildings: Building 01 – Main Building (consisting of the 1919 original building and 1924 and 1928 additions) and Building 02 – 1952 addition. Buildings 01 and 02 are separated by construction having a fire resistance rating of at least 2 hours. Because the deficiencies that triggered the FSES were cited in Building 01 (Main Building), this FSES covers that building only. The following factors served as the basis for this evaluation:

- Because the original building and additions were constructed prior to 07/05/2016, Ebenezer Care Center Building 01 (Main Building) was considered an existing building.
- Ebenezer Care Center Building 01 (Main Building) is three stories in height and has three separate unoccupied attics and a full basement. For purposes of this FSES, the four occupied building levels were divided into eleven (11) separate smoke zones.
- For purposes of this FSES, it was assumed that the basement level of the 1928 addition does not involve resident housing, treatment or customary access.

In accordance with NFPA 101A(2013), Sec. 4.2.3, a building must be able to achieve a score of zero (0) or better in all zones evaluated and in all four of the following parameters in FSES Worksheet 4.7.9 (Form CMS-2786T), ZONE FIRE SAFETY EQUIVALENCY EVALUATION:

- Containment Safety,
- Extinguishment Safety,
- People Movement Safety, and
- General Safety.

Because of an increase in the mandatory minimum score required in the column Extinguishment (Sb) in Worksheet 4.7.8B for zones located on the 3rd story, calculations show a negative score in the parameter *Extinguishment Safety* (S_2) in Worksheet 4.7.9 for the three (3) zones on that level. As a result, I regret to inform you that Ebenezer Care Center does **not** pass the FSES.

It would appear at this point that the only course of action available to Ebenezer Care Center to maintain its federal certification is to request a time-limited waiver for data tags K161, K211 and K233 cited during the facility's annual fire/life safety recertification survey conducted on 11/21/2018. As outlined in CMS Survey and Certification Memorandum S&C: 17-15-LSC (dated 12/16/2016), facilities that do not achieve a passing score for the individual safety evaluation *Extinguishment Safety* (S_2) in Worksheet 4.7.9 can be given a time-limited waiver for up to five (5) years to correct the deficiencies and come into compliance with the prescriptive requirements of the Life Safety Code or achieve an overall passing score on the FSES, including a passing score for *Extinguishment Safety* (S_2).

To receive the time-limited waiver, passing scores must be achieved in the other three parameters in Worksheet 4.7.9 – Containment Safety, People Movement Safety and General Safety. Based on the conditions found during the 12/06/2018 FSES evaluation and as reported in a follow-up email from Mr. Jason (Jay) Hill, Environmental Services Director, received at 1502 hours on 12/07/2018, all three of those parameters in all eleven (11) zones evaluated were found to have a score of zero or greater.

Should you have any questions or need additional information, please don't hesitate to get back to me.

Wishing you a safe day!

Robert L. Imholte

Robert L. Imholte
President
Fire Safety Resources, LLC

Enclosures

RLI/rli

FIRE SAFETY EVALUATION

Name of Facility: Ebenezer Care Center
Address: 2545 Portland Avenue South, Minneapolis, MN 55404
Phone: 612-879-2262
Licensed capacity: 127
Census at time of survey: 121

Evaluator: Robert L. Imholte, President, *Fire Safety Resources, LLC*

What follows is a report on the findings of a fire safety evaluation of the above-named facility that was conducted during an on-site visit to the facility between 0855 hours and 1430 hours on 12/06/2018. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(2013), *Guide on Alternative Approaches to Life Safety*. Based on this evaluation, Ebenezer Care Center has not achieved a passing score on the FSES.

In addition to observations made and documentation review conducted during the 12/06/2018 tour of the facility, the findings outlined herein are based on:

- Information provided by Ms. Christina Cauble, Facility Administrator; and Mr. Jason (Jay) Hill, Environmental Services Director; and
- A review of the Statement of Deficiencies (Form CMS-2567) from a state agency fire/life safety recertification survey conducted on 11/21/2018.
- A follow-up email communication received from Mr. Hill at 1502 hours on 12/07/2018 confirming that two fire sprinkler escutcheon plates found missing in Resident Room #138 on First Floor South have been replaced.

Initial Comments:
Ebenezer Care Center consists of two buildings: Building 01 – Main Building (consisting of the 1919 original building and 1924 and 1928 additions) and Building 02 – 1952 addition. Buildings 01 and 02 are separated by construction having a fire resistance rating of at least 2 hours. Because the deficiencies that triggered the FSES were cited in Building 01 (Main Building), this FSES covers that building only.

At the east end of the building's South Wing the nursing home is connected to a business occupancy called the Annex. At the west end of the basement level of the North Wing there is a connection to an adjacent apartment building. Because neither the Annex nor the apartment building is used for purposes of housing, treatment or customary access by the facility's residents and because both are separated from the nursing home by 2-hour-rated fire barriers, those buildings were not included in this evaluation.

Building 01 (Main Building) was determined to be of Type III(200) construction based on the following:

a. The original (Center) building was constructed in 1919 as a 3-story building with an attic and basement. This portion of the facility, constructed of masonry exterior bearing walls and wood floor/ceiling and roof assemblies was assigned a Type III(200) construction type in accordance with NFPA 220(2012), Sec. 4.4.1 and Table 4.1.1 (while the floor/ceiling assemblies on the upper levels are protected by gypsum wallboard/plaster on wire mesh, the basement ceiling is of exposed wood joist construction).
b. In 1924 a 3-story addition with an attic and basement was constructed to the north. Building construction was determined to be identical to that of the original (Center) building and was, therefore, assigned a construction type of Type III(200). In 1992 a new elevator, housed in a noncombustible shaft, was added to the north side of this wing.

c. In 1928 a 3-story addition with an attic and basement was constructed to the south. Again, building construction was determined to be identical to that of the original (Center) building and assigned a construction type of Type III(200).

Because the original building and additions were constructed prior to 07/05/2016, Ebenezer Care Center Building 01 (Main Building) is considered an existing building for federal certification purposes. The building was, therefore, treated as such for assigning values on the FSES worksheets.

Building 01 (Main Building) is three stories in height and has three separate attic spaces and a full basement. The attic spaces were found to be vacant and unoccupied and are protected by automatic sprinklers. The facility's residents are not allowed on this level. As allowed by NFPA 101A(13), Sec. 4.3.2(4)c, therefore, the attic level was not included in this evaluation. The facility has implemented the following measures to ensure that the attic spaces remain vacant and unoccupied:

- Facility staff has been notified that no storage is allowed in the attic areas
- The attic access doors are kept locked to restrict access to authorized personnel only
- Signage has been placed on all attic doors stating : "Authorized Personnel Only"
- Maintenance personnel tour the attics quarterly to ensure they remain empty and unused

The building is protected throughout by a supervised, wet-pipe automatic sprinkler system consisting of quick-response sprinklers. Based on documentation review, the system is being inspected, tested and maintained in accordance with NFPA 25.

Surveyor Note: Based on observation and interview of the environmental services director at the time of the 12/06/2018 on-site visit, the escutcheon plates were found missing on the two fire sprinklers in Resident Room #138 on First Floor South. As a result, it could not be confirmed that the sprinklers are installed and maintained in accordance with their listing as required by NFPA 13(10), Sec. 8.3.1.1 and NFPA 25(11), Sec. 5.2.1.

In a follow-up email communication received from the facility environmental services director, it was confirmed that the missing fire sprinkler escutcheon plates in Resident Room #138 were replaced on 12/07/2018. Photographic evidence and a copy of the sprinkler contractor's FIELD / SERVICE WORK ORDER were provided to serve as verification that the missing sprinkler escutcheon plates had been replaced. The findings in this report, therefore, reflect that the building's fire sprinkler protection is in conformance with the requirements of NFPA 101(12), Sec. 19.3.5.1 and the fire sprinkler system is now being inspected, tested and maintained in accordance with NFPA 25.

The facility has an addressable manual fire alarm system, which is monitored for automatic fire department notification. There is automatic smoke detection in the corridors and spaces open to the corridors and automatic heat detection in selected areas. Based on documentation review, the fire alarm system and automatic detectors are being inspected, tested and maintained in accordance with NFPA 72.

Building 01 (Main Building) is subdivided by fire barrier walls as follows:

- The original (Center) building is separated from the South Wing by a 2-hour-rated fire barrier.
- There are also 2-hour-rated fire barriers between the original (Center) building and the North Wing on the 2nd and 3rd floors.

For purposes of this FSES, the various building levels in Building 01 (Main Building) were divided into eleven (11) separate smoke zones as follows:

Zone 1 – Basement Center/North
Zone 2 – Basement South
Zone 3 – First Floor Center
Zone 4 – First Floor North
Zone 5 – First Floor South
Zone 6 – Second Floor Center
Zone 7 – Second Floor North
Zone 8 – Second Floor South
Zone 9 – Third Floor Center
Zone 10 – Third Floor North
Zone 11 – Third Floor South

This report is intended to serve as an explanation of the scores entered on FSES Worksheets 4.7.2, 4.7.6 and 4.7.10 (i.e. Forms CMS-2786T) for the facility as it was found on 12/06/2018 and as reported by the facility environmental services director in an email communication received on 12/07/2018. The score assigned to each item is noted in brackets ([ ]). It must be noted that numbers were rounded to the nearest tenth of a point and that measurements of over one-half inch were rounded to the nearest inch. To ensure that the FSES addresses the "worst-case scenario", the product of the multiplication in Worksheet 4.7.5 (i.e. value of "R") was rounded up to the nearest whole number. Code references are provided where appropriate. Codes referenced include the 2013 edition of NFPA 101A and the 2012 edition of the *Life Safety Code*® (NFPA 101).

With the exception of Worksheet 4.7.10, which applies to all zones, this narrative will address each of the eleven (11) zones separately.

All Levels – WORKSHEET 4.7.10. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

In accordance with NFPA 101A(13), Sec. 4.7.9, Step 9, only one copy of this table is required to be filled out for each building. For convenience, however, this table was filled out on the worksheets for all zones evaluated. All items in Worksheet 4.7.10 could be checked 'Met' with the exception of Items B and L, which were checked 'Not Applicable'. Because Ebenezer Care Center is an existing facility (Item B) and does not meet the definition of a high rise (Item L), these two items do not apply in this case. The remaining items were identified as 'Met' based on the following:

- Building utilities and heating and air conditioning systems appeared to be in conformance with NFPA 101(12), Sections 9.1 and 9.2.
- No incinerator or space heaters were found.
- The facility's evacuation plan and fire drill records were reviewed and appeared to be in order.
- The facility's smoking regulations were reviewed and appeared to be in order.
- Based on review of documentation, draperies, cubicle curtains, upholstered furniture, mattresses and decorations were found to be in accordance with NFPA 101(12), Sec. 19.7.5.
- Portable fire extinguishers, EXIT signage and emergency lighting appeared to be provided in accordance with applicable requirements.

Zone 1 – Basement Level Center/North:

WORKSHEET 4.7.2. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: While there are no sleeping rooms in this zone, some residents in the zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.0]: This level is used primarily for staff services, utilities and facility storage, but the corridor space from the north elevator to the 1952 addition (Building 02) located to the east is used on a regular basis during the day by facility residents to access the Beauty Shop and Adult Day Program located in the 1952 addition. It was reported that there are a maximum of four (4) residents in this zone at any one time.
3. Zone Location (*L*) [Value assigned = 1.6]: This zone is located below grade level.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.0]: It was reported that there is one (1) staff person for each two (2) residents present in this zone.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

WORKSHEET 4.7.6. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -4]:
   The building was assigned a Type III(200) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Documentation was provided certifying that the exposed wood in the ceiling in the corridors and spaces open to the corridor was treated with Flame Control No. 40-40A Fire Retardant Intumescent Paint to achieve a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: -3]:
   No documentation was provided proving that the exposed wood in the ceiling in some of the rooms separated from the corridor had a flame spread rating of better than Class C.
4. Corridor Partitions/Walls [Score: +2]:
   The corridor walls are of constructed of brick and extend to the floor deck above.
5. Doors to Corridor [Score: +1]:
   Corridor doors were found to be a mixture of 1¾-inch-thick steel and 20-minute-rated construction.
6. Zone Dimensions [Score: 0]:
   According to past review of architectural drawings, this zone measures approximately 145 feet in length.
7. Vertical Openings [Score: 0]:
   - Openings into most of the stair enclosures were found to be protected with 90-minute fire-rated self-closing door assemblies. The self-closing door at the top of the stairway connecting the basement level to the 1st Floor kitchen, however, was found to be of 1¾-inch solid wood core construction, which provides a fire resistance of less than 1 hour.
   - The loading doors into the soiled linen chute on the upper floors were also found to be protected with 90-minute fire-rated self-closing door assemblies. The door assembly into the chute termination room was found to carry a 60-minute fire protection rating.
8. Hazardous Areas [Score: 0]:
   Hazardous areas were found to be sprinkler protected and smoke-separated as required by NFPA 101A(13), Sec. 4.6.8.2.
9. Smoke Control [Score: 0]:
   A fire/smoke barrier serves this zone.

10. Emergency Movement Routes [Score: -2]:
    There are multiple distinctly separated movement routes from this zone, three of which are horizontal exits. However, because of utility piping (e.g. steam and water pipes) running across the corridor and across doorways, headroom at multiple locations was found to be only 69 - 75 inches instead of the 80 inches required by NFPA 101(12), Sec. 7.1.5.
11. Manual Fire Alarm [Score: +2]:
    There are manual fire alarm pull stations at each exit stair enclosure and at the bottom of the stair leading to the exterior near Kitchen Storeroom B-21. The fire alarm system is monitored by Armour Security.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. System-connected smoke detectors were found in the egress corridors and the zone is protected with quick-response sprinklers.
13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic sprinkler system consisting of quick-response sprinklers.

Zone 2 – Basement Level South:

WORKSHEET 4.7.2. OCCUPANY RISK PARAMETER FACTORS

The facility's residents are not allowed in this area of the basement. For purposes of this FSES, therefore, it was assumed that this level did not involve resident housing, treatment or customary access. This area of the basement was found to house maintenance, the facility laundry and storage. As a result, in accordance with instruction given in NFPA 101A(13), Sec. 4.3.2(4)a, only Item 3, Zone Location (*L*), of Worksheet 4.7.2 was addressed and the value of factor *F* in Worksheet 4.7.3, OCCUPANCY RISK FACTOR CALCULATION, was assigned a factor of 1.6 (i.e. the value assigned to basements in factor *L* of Worksheet 4.7.2).

WORKSHEET 4.7.6. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -4]:
   The building was assigned a Type III(200) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Ceiling finish was found to be plaster. Wall finish was found to be brick.
3. Interior Finish (Rooms) [Score: +3]:
   Wall and ceiling finish was found to be combination of gypsum and plaster.
4. Corridor Partitions/Walls [Score: +2]:
   For purposes of this FSES, this zone was treated as a non-patient-care suite in accordance with NFPA 101(12), Sec. 19.2.5.7. Based on building information provided at the time of the survey, this suite is approximately 4,256 ft^2 in size and is separated from the corridor in the adjacent 1919 original building by a 2-hour-rated fire barrier.
5. Doors to Corridor [Score: +2]:
   Again, for purposes of this FSES, this zone was treated as a suite in accordance with NFPA 101(12), Sec. 19.2.5.7. The door opening into the corridor in the adjacent 1919 original building was found to be a 90-minute fire-rated assembly.
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. According to building information provided, this zone measures approximately 112 feet in length and, based on actual measurements, has dead-ends in the hallway measuring approximately 30 feet in length at the east end and approximately 60 feet in length at the west end. Parameter 10, Emergency Movement Routes, is assigned a score of -8.

7. Vertical Openings [Score: 0]:
   This score was assigned per instruction in Footnote *e* to this Table. Openings into the stair enclosure in this zone were found to be protected with 90-minute fire-rated self-closing door assemblies. The loading doors into the soiled linen chute on the upper floors as well as the door into the chute termination room in this zone were also found to be 90-minute fire-rated self-closing door assemblies. However, Parameter 1, Construction, is based on an unprotected type of construction ("200").
8. Hazardous Areas [Score: 0]:
   Hazardous areas were found to be sprinkler protected and smoke-separated as required by NFPA 101A(13), Sec. 4.6.8.2.
9. Smoke Control [Score: 0]:
   A fire/smoke barrier serves this zone.
10. Emergency Movement Routes [Score: -8]:
    This score was assigned for the following reasons:
    - The two exits from this zone are not remotely located from each other as required by NFPA 101(12), Sec. 7.5.1.3.
    - Because of utility piping (e.g. steam and water pipes) running across the corridor, headroom at multiple locations was found to be only 73 - 75 inches instead of the 80 inches required by NFPA 101(12), Sec. 7.1.5.
11. Manual Fire Alarm [Score: +2]:
    There is a manual fire alarm pull station near the exit stair enclosure serving this zone. The fire alarm system is monitored by Armour Security.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. System-connected smoke detectors were found in the hallway and the zone is protected with quick-response sprinklers.
13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic sprinkler system consisting of quick-response sprinklers.

Zone 3 – First Floor Center

WORKSHEET 4.7.2. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in the zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 2.0]: Five (5) residents are housed in this zone. The zone also contains the facility dining room, gift shop and a lounge, however, which are available for use by all residents.
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.5]: It was reported that there is at least one (1) staff person assigned to this zone on the night shift.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

WORKSHEET 4.7.6. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -2]:
   The building was assigned a Type III(200) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in corridors and exits carry a Class A (25 or less) flame spread rating.

3. Interior Finish (Rooms) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in rooms carry a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +2]:
   Corridor walls are a mixture of gypsum wallboard and plaster on both sides of wood studs. A 32" x 44" wired glass vision panel mounted in a steel frame was observed in the corridor wall at Therapy Room 127. The Gift Shop was treated as a space open to the corridor as allowed by NFPA 101(12), Sec. 19.3.6.1(4) – it is protected by automatic fire sprinklers and automatic smoke detection. The IT closet, which has a transfer grille on one side, was also treated as a space open to the corridor as allowed by NFPA 101(12), Sec. 19.3.6.1(1) – it is protected by automatic fire sprinklers and automatic smoke detection.
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be of 1-5/8-inch-thick solid wood construction.
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. According to building information provided, this zone measures approximately 104 feet in length. Due to the lack of complying means of egress out of this level, a dead-end condition is created. Parameter 10, Emergency Movement Routes, was assigned a score of -8.
7. Vertical Openings [Score: 0]:
   The main stair enclosure in this zone is enclosed with construction providing a minimum 2-hour fire resistance. The self-closing door at the top of the stairway connecting the 1st Floor kitchen to the basement level, however, was found to be of 1¾-inch solid wood core construction, which provides a fire resistance of less than 1 hour.
8. Hazardous Areas [Score: 0]:
   Hazardous areas were found to be sprinkler protected and smoke-separated as required by NFPA 101A(13), Sec. 4.6.8.2.
9. Smoke Control [Score: 0]:
   There is a 1-hour-rated separation between this zone and the 1924 building and a 2-hour-rated fire separation between this zone and the 1928 building.
10. Emergency Movement Routes [Score: -8]:
    This score was assigned for the following reasons:
    - The corridor doors on this level were found to measure only 29-30 inches in clear width. As a result, they could not be credited as an egress route [see NFPA 101A(13), Sec. 4.6.10.3.2].
    - The second means of egress from the Dining Room was found to be through the adjoining Conservatory, as allowed by NFPA 101(12), Sec. 7.5.1.6, but the door from the Conservatory to the egress corridor swings against egress travel. Since the Dining room serves an occupant load of more than 50, this does not meet the requirements of NFPA 101(12), Sec. 7.2.1.4.2(1).
11. Manual Fire Alarm [Score: +2]:
    A manual fire alarm pull station was found along the path of travel to the main exit from this level. The fire alarm system is monitored by Armour Security.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. System-connected smoke detectors were found in the egress corridors and the zone is protected with quick-response sprinklers.
13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic sprinkler system consisting of quick-response sprinklers.

Zone 4 – First Floor North

WORKSHEET 4.7.2. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in the zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 2.0]: There is bed capacity for up to 17 residents in this zone. The zone also contains the facility chapel, which is available for use by all residents.
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.5]: It was reported that there are two staff persons attending this zone on the night shift. One staff person is assigned to make rounds of the remainder of the First Floor every 2 hours.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

WORKSHEET 4.7.6. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -2]:
   The building was assigned a Type III(200) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in corridors and exits carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in rooms carry a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +2]:
   Corridor walls are constructed of a mixture of gypsum and plaster on both sides of wood studs. The Chapel was treated as a space open to the corridor as allowed by NFPA 101(12), Sec. 19.3.6.1(1) – it is protected by automatic fire sprinklers and automatic smoke detection.
5. Doors to Corridor [Score: +1]:
   Corridor doors were found to be of 1-5/8-inch-thick solid wood construction.
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. According to building information provided, this zone measures approximately 112 feet in length. Due to the lack of complying means of egress out of this level, a dead-end condition is created. Parameter 10, Emergency Movement Routes, was assigned a score of -8.
7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table. Openings into the stair enclosures were found to be protected with 90-minute fire-rated self-closing door assemblies. The doors into the soiled linen chute in this zone were also found to be protected with 90-minute fire-rated self-closing door assemblies. The door assembly into the chute termination room was found to carry a 60-minute fire protection rating. However, Parameter 1, Construction, is based on an unprotected type of construction (“200”).
8. Hazardous Areas [Score: 0]:
   Hazardous areas were found to be sprinkler protected and smoke-separated as required by NFPA 101A(13), Sec. 4.6.8.2.
9. Smoke Control [Score: 0]:
   There is a 1-hour-rated fire separation between this zone and the adjacent 1919 building and a 2-hour-rated fire separation between this zone and the adjacent 1950 building.

10. Emergency Movement Routes [Score: -8]:
    This score was assigned for the following reasons:
    - The corridor doors on this level were found to measure only 29-30 inches in clear width. As a result, these components could not be credited as an egress route [see NFPA 101A(13), Sec. 4.6.10.3.2].
    - Access to the second exit from the Chapel is through a space used for storage, which does not meet the requirements of NFPA 101(12), Sec. 7.5.1.6.
    - An approximately 5-inch grade change was found outside the second exit from the Chapel, which does not meet the requirements of NFPA 101(12), Sec. 7.2.1.3.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations were found near the elevator lobby, at the second exit from the Chapel and at the nurses' station serving the zone, which meets the intent of NFPA 101(12), Sec. 19.3.4.2.2. The fire alarm system is monitored by Armour Security.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. System-connected smoke detectors were found in the egress corridors and the zone is protected with quick-response sprinklers.
13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic sprinkler system consisting of quick-response sprinklers.

Zone 5 – First Floor South

WORKSHEET 4.7.2. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in the zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to eight (8) residents in this zone. The zone also contains an exercise/physical therapy space. It was reported that there are a maximum of three (3) residents in the therapy space at any one time.
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.2]: It was reported that there is at least one (1) staff person assigned to this zone on the night shift. It was reported that when residents are present in the exercise/physical therapy space, a 1:1 staff ratio is maintained.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

WORKSHEET 4.7.6. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -2]:
   The building was assigned a Type III(200) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in corridors and exits carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in rooms carry a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: 0]:
   Corridor walls are constructed of a mixture of gypsum and plaster on both sides of wood studs. A 32" x 46" wired glass vision panel in a wood frame was found in the corridor wall at the physical therapy space. As a result, the corridor walls were graded as "<½ hour".

5. Doors to Corridor [Score: +1]:
   Corridor doors were found to be of 1-5/8-inch-thick solid wood construction.
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. According to building information provided, this zone measures approximately 126 feet in length. Due to the lack of complying means of egress out of this level, a dead-end condition is created. Parameter 10, Emergency Movement Routes, was assigned a score of -8.
7. Vertical Openings [Score: 0]:
   This score was assigned per instruction in Footnote *e* to this Table. Openings into the stair enclosures, soiled linen chute and chute termination room in this zone were found to be protected with 90-minute fire-rated self-closing door assemblies; however, Parameter 1, Construction, is based on an unprotected type of construction ("200").
8. Hazardous Areas [Score: 0]:
   Hazardous areas were found to be sprinkler protected and smoke-separated as required by NFPA 101A(13), Sec. 4.6.8.2.
9. Smoke Control [Score: 0]:
   There is a 2-hour-rated fire separation between this zone and the adjacent 1924 building.
10. Emergency Movement Routes [Score: -8]:
    The corridor doors in this zone were found to measure only 29-30 inches in clear width. As a result, they could not be credited as an egress route [see NFPA 101A(13), Sec. 4.6.10.3.2].
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations were found along the path of egress travel to both exterior exit doors from this zone. The fire alarm system is monitored by Armour Security.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. System-connected smoke detectors were found in the egress corridors and the zone is protected with quick-response sprinklers.
13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic sprinkler system consisting of quick-response sprinklers.

Zone 6 – Second Floor Center

WORKSHEET 4.7.2. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in the zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to 11 residents in this zone.
3. Zone Location (*L*) [Value assigned = 1.2]: This zone is one floor height above First Floor.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.5]: It was reported that there is at least one (1) staff person assigned to this zone on the night shift.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

WORKSHEET 4.7.6. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -4]:
   The building was assigned a Type III(200) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in corridors and exits carry a Class A (25 or less) flame spread rating.

3. Interior Finish (Rooms) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in rooms carry a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +2]:
   Corridor walls are constructed of a mixture of gypsum and plaster on both sides of wood studs.
5. Doors to Corridor [Score: +1]:
   Corridor doors were found to be of 1-5/8-inch-thick solid wood construction.
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. According to building information provided, this zone measures approximately 104 feet in length. Due to the lack of complying means of egress out of this level, a dead-end condition is created. Parameter 10, Emergency Movement Routes, was assigned a score of -8.
7. Vertical Openings [Score: 0]:
   This score was assigned per instruction in Footnote *e* to this Table. The stair enclosure in this zone is enclosed with construction providing a minimum 2-hour fire resistance, but Parameter 1, Construction, is based on an unprotected type of construction ("200").
8. Hazardous Areas [Score: 0]:
   Hazardous areas were found to be sprinkler protected and smoke-separated as required by NFPA 101A(13), Sec. 4.6.8.2.
9. Smoke Control [Score: 0]:
   There are 2-hour-rated fire separations at both ends of this zone, which separate this zone from the adjacent 1924 and 1928 buildings.
10. Emergency Movement Routes [Score: -8]:
    The corridor doors on this level were found to measure only 29-30 inches in clear width. As a result, they could not be credited as an egress route [see NFPA 101A(13), Sec. 4.6.10.3.2].
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations were found along the path of travel from this zone and at the nurses' station serving the zone, which meets the intent of NFPA 101(12), Sec. 19.3.4.2.2. The fire alarm system is monitored by Armour Security.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. System-connected smoke detectors were found in the egress corridors and the zone is protected with quick-response sprinklers.
13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic sprinkler system consisting of quick-response sprinklers.

Zone 7 – Second Floor North

WORKSHEET 4.7.2. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in the zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to 15 residents in this zone.
3. Zone Location (*L*) [Value assigned = 1.2]: This zone is one floor height above First Floor.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.5]: It was reported that there is at least one (1) staff person assigned to this zone on the night shift.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

WORKSHEET 4.7.6. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -4]:
   The building was assigned a Type III(200) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in corridors and exits carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in rooms carry a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +2]:
   Corridor walls are constructed of a mixture of gypsum and plaster on both sides of wood studs.
5. Doors to Corridor [Score: +1]:
   Corridor doors were found to be of 1-5/8-inch-thick solid wood construction. A transfer grille was found in the door to the IT closet located in this zone. As allowed by NFPA 101(12), Sec. 19.3.6.1(1), this closet was treated as a space open to the corridor – it is protected by automatic fire sprinklers and automatic smoke detection. For purposes of this FSES, therefore, this door was not considered in classifying "Doors to Corridor".
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. According to building information provided, this zone measures approximately 112 feet in length and was found to have a dead-end of approximately 50 feet in length. Parameter 10, Emergency Movement Routes, was assigned a score of -8.
7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table. Openings into the stair enclosures were found to be protected with 90-minute fire-rated self-closing door assemblies. The doors into the soiled linen chute were also found to be protected with 90-minute fire-rated self-closing door assemblies. The door assembly into the chute termination room was found to carry a 60-minute fire protection rating. Parameter 1, Construction, is based on an unprotected type of construction ("200").
8. Hazardous Areas [Score: 0]:
   Hazardous areas were found to be sprinkler protected and smoke-separated as required by NFPA 101A(13), Sec. 4.6.8.2.
9. Smoke Control [Score: 0]:
   There are 2-hour-rated fire separations between this zone and the adjacent 1924 and 1950 buildings.
10. Emergency Movement Routes [Score: -8]:
    The door to the exterior from the east exit enclosure in this zone measures only 30 inches in clear width, which does not meet the requirements of NFPA 101(12), Sec. 19.2.3.6. The corridor doors on this level were found to measure only 29-30 inches in clear width. As a result, these components could not be credited as an egress route [see NFPA 101A(13), Sec. 4.6.10.3.2]
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations were found near the elevator lobby and at the nurses' station serving the zone, which meets the intent of NFPA 101(12), Sec. 19.3.4.2.2. The fire alarm system is monitored by Armour Security.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. System-connected smoke detectors were found in the egress corridors and the zone is protected with quick-response sprinklers.

13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic sprinkler system consisting of quick-response sprinklers.

Zone 8 – Second Floor South

WORKSHEET 4.7.2. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in the zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to 15 residents in this zone.
3. Zone Location (*L*) [Value assigned = 1.2]: This zone is one floor height above First Floor.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.5]: It was reported that there is at least one (1) staff person assigned to this zone on the night shift.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

WORKSHEET 4.7.6. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -4]:
   The building was assigned a Type III(200) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in corridors and exits carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in rooms carry a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +2]:
   Corridor walls are constructed of a mixture of gypsum and plaster on both sides of wood studs. The dining/lounge area is open to the corridor as allowed by NFPA 101(12), Sec. 19.3.6.1(1) – it is protected by automatic fire sprinklers and automatic smoke detection.
5. Doors to Corridor [Score: +1]:
   Corridor doors were found to be of 1-5/8-inch-thick solid wood construction.
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. According to building information provided, this zone measures approximately 126 feet in length and was found to have a dead-end of approximately 45 feet in length at the east end of the corridor. Parameter 10, Emergency Movement Routes, was assigned a score of -8.
7. Vertical Openings [Score: 0]:
   This score was assigned per instruction in Footnote *e* to this Table. Openings into the stair enclosures, soiled linen chute and chute termination room in this zone were found to be protected with 90-minute fire-rated self-closing door assemblies; however, Parameter 1, Construction, is based on an unprotected type of construction (“200”).
8. Hazardous Areas [Score: 0]:
   Hazardous areas were found to be sprinkler protected and smoke-separated as required by NFPA 101A(13), Sec. 4.6.8.2.
9. Smoke Control [Score: 0]:
   There is a 2-hour-rated fire separation between this zone and the adjacent 1919 building.

10. Emergency Movement Routes [Score: -8]:
    This score was assigned for the following reasons:
    - The corridor doors in this zone were found to measure only 29-30 inches in clear width. As a result, they could not be credited as an egress route [see NFPA 101A(13), Sec. 4.6.10.3.2].
    - The doors into the exit stair enclosures serving this zone swing against egress travel, which does not meet the requirements of NFPA 101(12), Sec. 7.2.1.4.2(2).
11. Manual Fire Alarm [Score: +2]:
    A manual fire alarm pull station was found at the nurses' station serving the zone, which meets the intent of NFPA 101(12), Sec. 19.3.4.2.2. The fire alarm system is monitored by Armour Security.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. System-connected smoke detectors were found in the egress corridors and the zone is protected with quick-response sprinklers.
13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic sprinkler system consisting of quick-response sprinklers.

Zone 9 – Third Floor Center

WORKSHEET 4.7.2. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in the zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to 11 residents in this zone.
3. Zone Location (*L*) [Value assigned = 1.2]: This zone is two floor heights above First Floor.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.5]: It was reported that there is at least one (1) staff person assigned to this zone on the night shift.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

WORKSHEET 4.7.6. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -9]:
   The building was assigned a Type III(200) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in corridors and exits carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in rooms carry a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +2]:
   Corridor walls are constructed of a mixture of gypsum and plaster on both sides of wood studs.
5. Doors to Corridor [Score: +1]:
   Corridor doors were found to be of 1-5/8-inch-thick solid wood construction.
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. According to building information provided, this zone measures approximately 104 feet in length. Due to the lack of complying means of egress out of this level, a dead-end condition is created. Parameter 10, Emergency Movement Routes, was assigned a score of -8.

7. Vertical Openings [Score: 0]:
   This score was assigned per instruction in Footnote *e* to this Table. The stair enclosure in this zone is enclosed with construction providing a minimum 2-hour fire resistance, but Parameter 1, Construction, is based on an unprotected type of construction ("200").
8. Hazardous Areas [Score: 0]:
   Hazardous areas were found to be sprinkler protected and smoke-separated as required by NFPA 101A(13), Sec. 4.6.8.2.
9. Smoke Control [Score: 0]:
   There are 2-hour-rated fire separations at both ends of this zone, which separate this zone from the adjacent 1924 and 1928 buildings.
10. Emergency Movement Routes [Score: -8]:
    The corridor doors on this level were found to measure only 29-30 inches in clear width. As a result, they could not be credited as an egress route [see NFPA 101A(13), Sec. 4.6.10.3.2].
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations were found along the path of travel and at the nurses' station serving the zone, which meets the intent of NFPA 101(12), Sec. 19.3.4.2.2. The fire alarm system is monitored by Armour Security.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. System-connected smoke detectors were found in the egress corridors and the zone is protected with quick-response sprinklers.
13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic sprinkler system consisting of quick-response sprinklers.

Zone 10 – Third Floor North

WORKSHEET 4.7.2. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in the zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to 14 residents in this zone.
3. Zone Location (*L*) [Value assigned = 1.2]: This zone is two floor heights above First Floor.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.2]: It was reported that there are two (2) staff persons assigned to this zone on the night shift resulting in a ratio of one (1) staff for each seven (7) residents.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

WORKSHEET 4.7.6. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -9]:
   The building was assigned a Type III(200) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in corridors and exits carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in rooms carry a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +2]:
   Corridor walls are constructed of a mixture of gypsum and plaster on both sides of wood studs.

5. Doors to Corridor [Score: +1]:
   Corridor doors were found to be of 1-5/8-inch-thick solid wood construction. A transfer grille was found in the door to the IT closet located in this zone. As allowed by NFPA 101(00), Sec. 19.3.6.1(1), this closet was treated as a space open to the corridor – it is protected by automatic fire sprinklers and automatic smoke detection. For purposes of this FSES, therefore, this door was not considered in classifying "Doors to Corridor".
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. According to building information provided, the zone measures approximately 112 feet in length and was found to have a dead-end of approximately 50 feet in length. Parameter 10, Emergency Movement Routes, was assigned a score of -8.
7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table. Openings into the stair enclosures were found to be protected with 90-minute fire-rated self-closing door assemblies. The doors into the soiled linen chute were also found to be protected with 90-minute fire-rated self-closing door assemblies. The door assembly into the chute termination room was found to carry a 60-minute fire protection rating. Parameter 1, Construction, is based on an unprotected type of construction ("200").
8. Hazardous Areas [Score: 0]:
   Hazardous areas were found to be sprinkler protected and smoke-separated as required by NFPA 101A(13), Sec. 4.6.8.2.
9. Smoke Control [Score: 0]:
   There are 2-hour-rated fire separations between this zone and the adjacent 1919 and 1950 buildings.
10. Emergency Movement Routes [Score: -8]:
    The door to the exterior from the east exit enclosure in this zone measures only 30 inches in clear width, which does not meet the requirements of NFPA 101(12), Sec. 19.2.3.6. The corridor doors on this level were found to measure only 29-30 inches in clear width. As a result, these components could not be credited as an egress route [see NFPA 101A(13), Sec. 4.6.10.3.2].
11. Manual Fire Alarm [Score: +2]:
    A manual fire alarm pull station was found adjacent to the door into the east exit enclosure and at the nurses' station serving the zone, which meets the intent of NFPA 101(12), Sec. 19.3.4.2.2. The fire alarm system is monitored by Armour Security.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. System-connected smoke detectors were found in the egress corridors and the zone is protected with quick-response sprinklers.
13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic sprinkler system consisting of quick-response sprinklers.

Zone 11 – Third Floor South

WORKSHEET 4.7.2. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in the zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to 14 residents in this zone.
3. Zone Location (*L*) [Value assigned = 1.2]: This zone is two floor heights above First Floor.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.5]: It was reported that there is at least one (1) staff person assigned to this zone on the night shift.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

WORKSHEET 4.7.6. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -9]:
   The building was assigned a Type III(200) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in corridors and exits carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in rooms carry a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +2]:
   Corridor walls are constructed of a mixture of gypsum and plaster on both sides of wood studs. The dining/lounge area is open to the corridor as allowed by NFPA 101(12), Sec. 19.3.6.1(1) – it is protected by automatic fire sprinklers and automatic smoke detection.
5. Doors to Corridor [Score: +1]:
   Corridor doors were found to be of 1-5/8-inch-thick solid wood construction.
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. According to building information provided, this zone measures approximately 126 feet in length and was found to have a dead-end of approximately 40 feet in length at the east end of the corridor. Parameter 10, Emergency Movement Routes, was assigned a score of -8.
7. Vertical Openings [Score: 0]:
   This score was assigned per instruction in Footnote *e* to this Table. Openings into the stair enclosures, soiled linen chute and chute termination room in this zone were found to be protected with 90-minute fire-rated self-closing door assemblies; however, Parameter 1, Construction, is based on an unprotected type of construction (“200”).
8. Hazardous Areas [Score: 0]:
   Hazardous areas were found to be sprinkler protected and smoke-separated as required by NFPA 101A(13), Sec. 4.6.8.2.
9. Smoke Control [Score: 0]:
   There is a 2-hour-rated fire separation between this zone and the adjacent 1919 building.
10. Emergency Movement Routes [Score: -8]:
    This score was assigned for the following reasons:
    - The corridor doors in this zone were found to measure only 29-30 inches in clear width. As a result, they could not be credited as an egress route [see NFPA 101A(13), Sec. 4.6.10.3.2].
    - The doors into the exit stair enclosures serving this zone swing against egress travel, which does not meet the requirements of NFPA 101(12), Sec. 7.2.1.4.2(2).

11. Manual Fire Alarm [Score: +2]:
    There is a manual fire alarm pull station at the nurses' station, which meets the intent of NFPA 101(12), Sec. 19.3.4.2.2. The fire alarm system is monitored by Armour Security.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. System-connected smoke detectors were found in the egress corridors and the zone is protected with quick-response sprinklers.
13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic sprinkler system consisting of quick-response sprinklers.

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It must be noted that the scores and values assigned to the parameters in the tables on the FSES worksheets are based on conditions found during an on-site visit to the facility between 0855 hours and 1430 hours on 12/06/2018 and as reported by the facility environmental services director in an email communication received at 1502 hours on 12/07/2018. Any changes in those conditions after those dates could affect the scores and values, either positively or negatively. Again, based on this evaluation, Ebenezer Care Center **does not** achieve a passing score on the FSES. No other assessment of the level of safety in this facility is either intended or implied by *Fire Safety Resources, LLC*.