"In the spirit of community"
Franklin County
Rehab Center, LLC

Franklin County Rehab and Adult Care Center
110 Fairfax Road, St. Albans, VT 05478 • Ph. (802) 752-1600 • Fax. (802) 752-1666

VIA ELECTRONIC DELIVERY

June 16, 2023

Ms. Donna Jerry
Senior Health Policy Analyst
Green Mountain Care Board
144 State Street
Montpelier, Vermont 054602

RE: Docket No. GMCB-007-23con, Transfer of 30 Skilled Nursing Facility Beds from The Villa Rehab Center to Franklin County Rehab, LLC and the Construction of an Addition to Accommodate 30 Beds and Associated Space.

Dear Ms. Jerry,

Thank you for your letter dated June 6, 2023, with questions about my request for a waiver under Section 5 of Act 4, An Act Relating to Extending the COVID-19 Health Care Regulatory Flexibility. Please see my responses below.

1. **Describe in detail the grounds for your request for waiver under Section 5 of Act 4, An Act Relating to Extending COVID-19 Health Care Regulatory Flexibility.**

We are respectfully seeking a waiver of the certificate of need requirements, or, in the alternative, leave to file an emergency CON on the following grounds.

i. The financial situation at the Villa Rehab Center, LLC is extremely dire. We requested Emergency Financial Relief from the State and Vermont in the amount of six hundred thousand dollars to pay back bills associated with agency nursing

costs. The Villa asked for financial relief under the Emergency Financial Relief Hardship from the Division of Rate Setting. The census has not recovered since the beginning of the pandemic. Prior to the pandemic, The Villa had an occupancy percentage of 73.5% for 2019. The Villa has not been able to reach that level of occupancy for the past 3 years, (2020-61.7%; 2021-54.2%; 2022-59.6%). The Villa has not been able to pay vendors in a timely manner. As of April 30, 2023, The Villa Accounts Payable aging is $518,390.24. 70% ($361,645.87) of the vendors are beyond vendor payment terms (greater than 30 days). As a result, The Villa often receives demand letters for payment and incurs additional interest costs. Patient revenue has not covered the operating expenses since the start of the pandemic. The Villa has relied on Extraordinary Financial Relief from the State of Vermont and grants from the Department of Health and Human Services to meet payment needs. Going forward, these options/funds are not available to The Villa.

The cost to operate The Villa has increased substantially in the past year. The operating costs for 2022 were $3,259,570, comparative to the operating cost of $2,695,118 in 2021. The increase is primarily due to hiring contract staff to fill positions because of the staffing crisis in the healthcare industry. The Villa had contract staff in the amount of $505,367 for 2022 and $279,098 in 2021. The use of contract staff has continued into 2023, and for this year to date The Villa has currently incurred a total of $215,941. We anticipate a total expense of $650,000 for contract staff for the current year.

ii. COVID-19 led to a severe workforce shortage at The Villa, resulting in the forced use of prohibitively expensive agency staff. This dynamic has directly affected The Villa's ability to admit patients awaiting discharge from Vermont hospitals.

The Villa admits patients from Northwestern Medical Center and the University of Vermont Medical Center, among other hospitals. Patients are waiting for longer periods for a bed in a skilled nursing facility, resulting in increased costs to the health care system and impacting hospitals' abilities to care for patients with acute needs.

Allowing my team to begin this project immediately will help alleviate these pressures. Having all residents in one location, rather than at two different locations, allows us to maximize staffing flexibility and coverage. Relocating The Villa's staff and residents to the Franklin County Rehab Center campus will allow for certain positions to be consolidated, such as Nursing Home Administrator, Director of Nursing, Dietary Manager, Social Service Manager, Activity Director, Maintenance Director, MDS RN, Rehab Director, etc.

iii. Another result of COVID-19 centers around physician services. The Villa has struggled to recruit and retain physician services due to an exodus of geriatric providers from Vermont during the public health emergency. By relocating The Villa residents to the Franklin County Rehab Center campus, we will be able to assist in more efficiently accessing physician coverage for the residents.

iv. COVID-19 highlighted the need for private rooms to maintain better infection control and prevent the spread of disease and infection. Private spaces have been critical in the ongoing fight against COVID-19, and our residents are a particularly vulnerable population. The relocated beds at Franklin County Rehab Center will provide us with the opportunity to improve care and outcomes, as all thirty (30) beds would be transitioned to single-occupancy rooms. The Villa is comprised of one single-occupancy room, two triple occupancy rooms, and the remaining rooms are double occupancy. The layout of the rooms is not conducive to the level of care our residents require. Nursing home acuity has changed over the past several years requiring additional equipment for higher needs of the patients.

I am concerned about my ability to keep The Villa's thirty (30) beds open, absent the relief requested herein. The staffing challenge exacerbated by the pandemic has placed The Villa in a very difficult financial situation, causing me to request financial relief from Vermont's Agency of Human Services. The staffing challenge has artificially depressed census due to the prohibitively expensive staff, so that The Villa has been unable to generate the revenue needed to sustain itself. The financial concerns are compounded when coupled with the anticipated costs associated with the life safety issue that is detailed further in detail in response to Question Seven below.

2. Provide the total estimated cost of this project, including demolition and new construction costs.

i. I have engaged E4H Healthcare Architects and DEW Construction to provide me with estimated costs of this project. We have preliminary plans drawn. The addition would be approximately 18,000 square feet and would be built off one of the current wings of Franklin County Rehab Center. Construction costs are estimated to be around three hundred and fifty dollars a square foot ($350/sq ft) with an estimated cost of approximately six million three hundred thousand dollars ($6,300,000).

ii. I own the adjoining property located at 134 Fairfax Road, which is currently rented for both facilities. It is used for storage and an employee training center. The employee training center is used for orientation, licensed nursing assistant training program and staff education. These areas are incorporated into the preliminary plans for the addition.

The storage / training center building is approximately six thousand square feet and will be demolished in order to provide land for the addition. The building demolition is estimated to be around twenty thousand dollars or less ($20,000). Most of the building structure is a non-insulated pole barn where there is current storage.

Estimated Project Costs	
Architect, Mechanical, Structural, Electrical, plumbing, and civil design, design development, construction documents	481,000
Addition: 18,000 sqft (x) $350/sqft Construction Costs	6,300,000
Demolition of 134 Fairfax Building	20,000
Furnishing & Equipment	200,000
134 Mortgage Pay off.	289,000
Finance Costs (HUD 241) Second Mortgage	120,000
Total	**$7,410,000**

3. Provide an explanation of how the project will be financed including debt financing and percent interest associated with the debt financing.

i. Franklin County Rehab Center has a current HUD 232 loan on the existing building. The financing plan for this addition of 30 private rooms would be financed under a HUD 241 loan, which is used as a second mortgage for renovations and additions. Our current HUD lender is Lument Capital. We are working with them to apply for a HUD 241 loan. The current interest rate is 6.25%, with a Mortgage Insurance Premium of .72% and a Financing Fee of 1%, which is a mortgageable expense.

ii. An estimated project cost of approximately seven million (7 million). HUD requires a minimum ten percent (10%) down payment, leaving an estimated financed loan of approximately around $6,229,000.

4. Provide the estimated total square footage and cost per square foot.

i. The addition that will be built on to Franklin County Rehab Center will be approximately 18,000 square feet. The addition will include thirty private rooms with bathrooms using the licenses transferred from the Villa Rehab Center. The addition will also include a nursing station, office space, dining room with a small kitchen and rehab gym. The cost per square foot will be approximately three hundred and fifty dollars per square foot. ($350/sq ft).

5. Provide a detailed timeline outlining each phase of the project, including engaging architects and engineers, developing schematic level plans, and complying with all

regulatory requirements, including but not limited to Act 250 and local zoning permits requited and engaging a contractor to build the addition.

i. E4H Healthcare Architects have been engaged and presented a preliminary design and sent out for contracts for engineers.
ii. A pre-construction contract has been signed with DEW construction out of Williston, Vermont. April – May of 2023.
iii. Cross Consulting has been hired to handle the civil engineering of the project. There was an ACT 250 permit when the building was built, and an amendment will have to be made but the timeline should be less than six months. However, we will have to start that process as soon as possible. The civil engineer does not feel that there would be a problem with the update.
iv. The architect, contractor, and civil engineer were the original architect and builder of Franklin County Rehab Center when it was constructed in 2004.
v. Construction documents will be completed no later than December 2023.
vi. We are actively meeting and finalizing the design.
vii. The financing process has been begun with Lument Capital, which has provided a timeline of less than twelve months to obtain financing to allow construction to start in April of 2024.
viii. Construction of the addition will start approximately April 2024 and is planned to be completed within ten to twelve months. The opening of the new addition is planned for spring of 2025.

6. Identify the projected month and year when construction of the addition will begin.

i. The projected time for the start of construction would be April 2024.
ii. Please Attachment A: Preliminary architectural drawing of proposed addition.

7. Describe in more detail your concern regarding the impact of maintaining The Villa Rehab Center's (The Villa) thirty beds at its present location.

i. The Villa's financial sustainability is very dire at the current location, and closure of this facility will be imminent if we are not able to transfer the beds to Franklin County Rehab. The COVID-19 pandemic impacted this facility tremendously, and unfortunately we have not been able to recover. We had to limit admissions to our facility due to the pandemic. Our occupancy during the pandemic dropped to 54% and has not bounced back to its pre-pandemic rate.
ii. The physical plant is extremely challenged with the ability to ensure proper infection control practices in small double rooms.
iii. There is not adequate staff area to work and maintain a six-foot working distance.
iv. The Villa has limited private rooms and the residents share bathrooms.
v. We do not have the ability to move residents if they have an infectious disease and/or exposure in order to provide proper infection control procedures. A resident's roommate automatically would be exposed and continue to be exposed to the infected resident.
vi. We had multiple outbreaks of COVID within the patient population and staff population.

vii. The facility has two rooms that have three residents in a room.

viii. We do not have the ability to install proper air handling systems within the aging facility.

ix. The staffing challenge has also placed The Villa in a very difficult financial situation, causing me to request financial relief from Vermont's Agency of Human Services.

x. The staffing challenge has impacted our census as we are unable to afford the agency staff needed to run the facility at capacity and are not able to admit patients thus not able to generate the revenue needed to sustain itself.

xi. A Life Safety Code (LSC) comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on July 28, 2022, following a Vermont Division of Licensing and Protection State Survey. At this comparative Federal monitoring survey, The Villa Rehab was found to not be in substantial compliance with the 2012 Life Safety Code. Chapter 19 Existing Health Care Occupants. The Villa had never been cited for any deficiencies in this area regarding its building construction and type before. The Villa was required to do a Fire Safety Evaluation System (FSES). That analysis was done on October 22, 2022, and the building did not pass. At that time, we hired Jensen Hughes Life Safety Engineering firm out of Massachusetts and additional analysis and recommendations. There were a lot of recommendations to bring The Villa into compliance, but the largest barrier is that the third floor will prohibit a passing score. We would have to do construction upgrades and render the third floor unoccupiable. The basement would also have to be upgraded, and the cost of upgrading the basement and floor 1 and floor 2 is cost prohibitive and that will not address the fact that the third floor which houses all the office space for the Administrator, MDS Department, Activities, Director of Nurses and social services would have to be shut down. The Villa does not have the space to do an addition to the building for office spaces. The Villa is in a residential area and does not have enough land to accommodate an addition.

xii. We had a contractor come through and, in their estimate, it would be over four hundred thousand dollars and that would not give us access to the third floor of the building, which is necessary to operate the building.

xiii. We are currently under a temporary waiver until we can transfer The Villa's thirty beds to the Franklin County Rehab location.

8. Explain your plans for the Villa if the thirty beds were to be transferred to the Franklin County Rehab Center (FCRC) location.

i. There are many options for The Villa building. The owner will explore selling the building. It has been identified it could be used for a small residential care home, a group home, senior housing, nurse agency housing, a daycare center, hospice home, or a private home. The owner will reach out to the following agencies and potential buyers when there is confirmation that the project is approved, and the project is more concrete.

9. Please identify the distance between The Villa and FCRC.

i. The distance between The Villa and FCRC is .7 miles. It is less than a mile from the FCRC campus and makes the most sense to add an addition to FCRC. There will be many efficiencies of operations and costs if there is a consolidation.

10. Explain in detail how and when the residents of The Villa will be notified of the potential change in location.

i. The residents of The Villa will be notified of the potential change in location is and when the GMCB approves the waiver and the financing is confirmed. The project will take 12 months to complete. The owner will ensure that the residents, staff, and family members are kept informed of the project. Coleen Condon, owner did have a meeting with department heads of The Villa on June 8, 2023 and let them know about the potential transfer of the beds from The Villa to the FCRC building by adding an addition onto FCRC.

11. Provide the Centers for Medicare and Medicaid's (CMS) overall star ratings for the Villa and for FCRC for the most recent three-year period.

i. See attachment marked Attachment Q11.

12. Provide copies of the most recent surveys for The Villa and FCRC conducted on behalf of CMS by the Department of Disabilities, Aging and Independent Living and Plans of Correction.

i. See attachment marked Question 12 Villa and Question 12 FCRC

13. Provide copies of the annual Health and Safety Inspection results for the two most recent years for the Villa and FCRC.

i. See attachment marked Question 13 Villa and Question 13 FCRC

14. Explain whether The Villa or FCRC has, in the past five years, been fined, had penalties imposed, or had payments denied or withheld by CMS or any other state or federal entity.

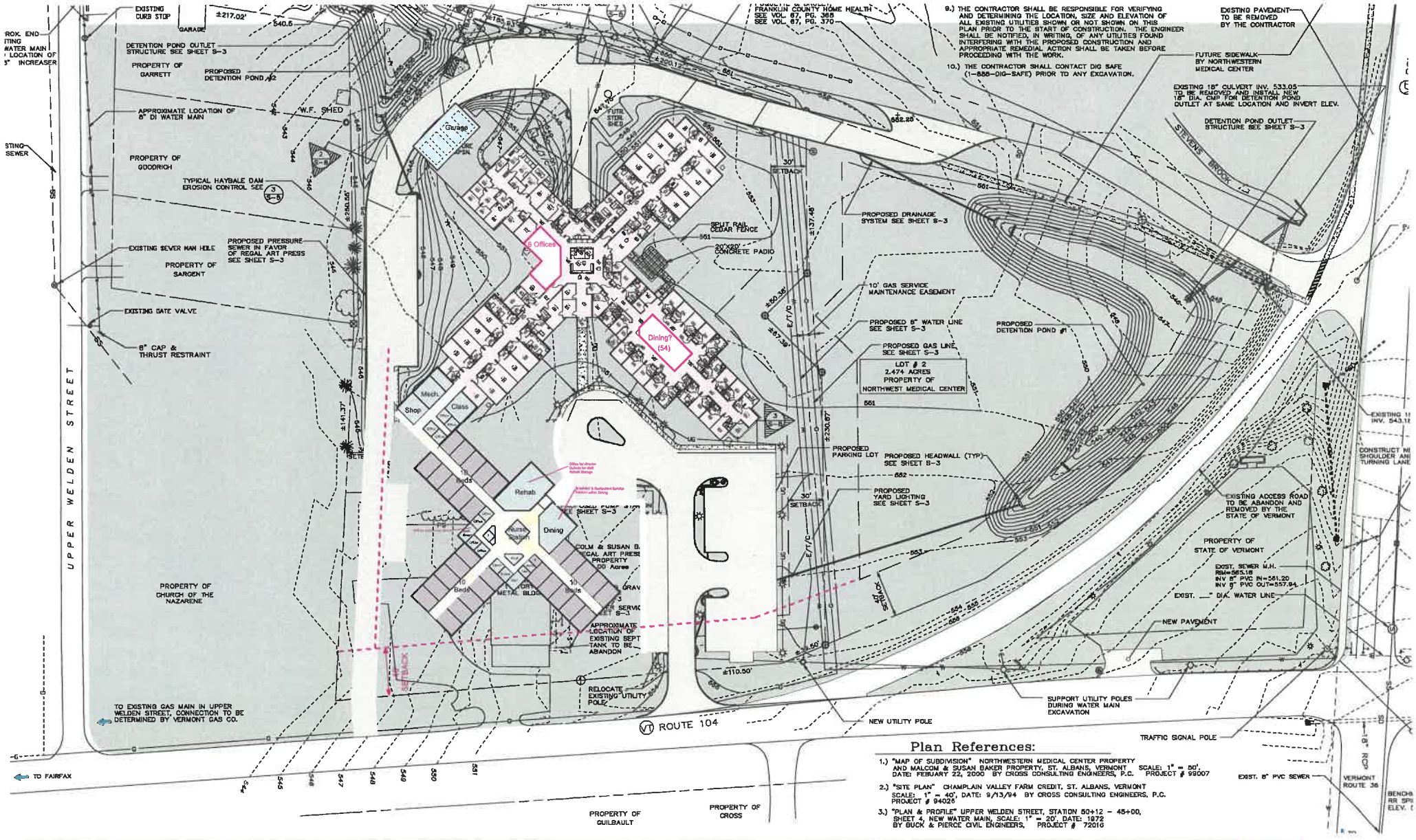
i. FCRC has not been subjected to any of the above penalties. The Villa in 2019 was fined a Civil Money Penalty regarding a resident fall, which is attached and marked as Question 14.

Sincerely,

Coleen Condon

Coleen Condon
Owner

Attachment A



Plan References:

1.) "MAP OF SUBDIVISION" NORTHWESTERN MEDICAL CENTER PROPERTY AND MALCOM & SUSAN BAKER PROPERTY, ST. ALBANS, VERMONT SCALE: 1" = 50', DATE: FEBUARY 22, 2000 BY CROSS CONSULTING ENGINEERS, P.C. PROJECT # 99007

2.) "SITE PLAN" CHAMPLAIN VALLEY FARM CREDIT, ST. ALBANS, VERMONT SCALE: 1" = 40', DATE: 9/13/94 BY CROSS CONSULTING ENGINEERS, P.C. PROJECT # 94025

3.) "PLAN & PROFILE" UPPER WELDEN STREET, STATION 50+12 - 45+00, SHEET 4, NEW WATER MAIN, SCALE: 1" = 20', DATE: 1972 BY BUCK & PIERCE CIVIL ENGINEERS, PROJECT # 72016

Franklin County Rehab 30 Bed Expansion

Site Plan

09 May 2023

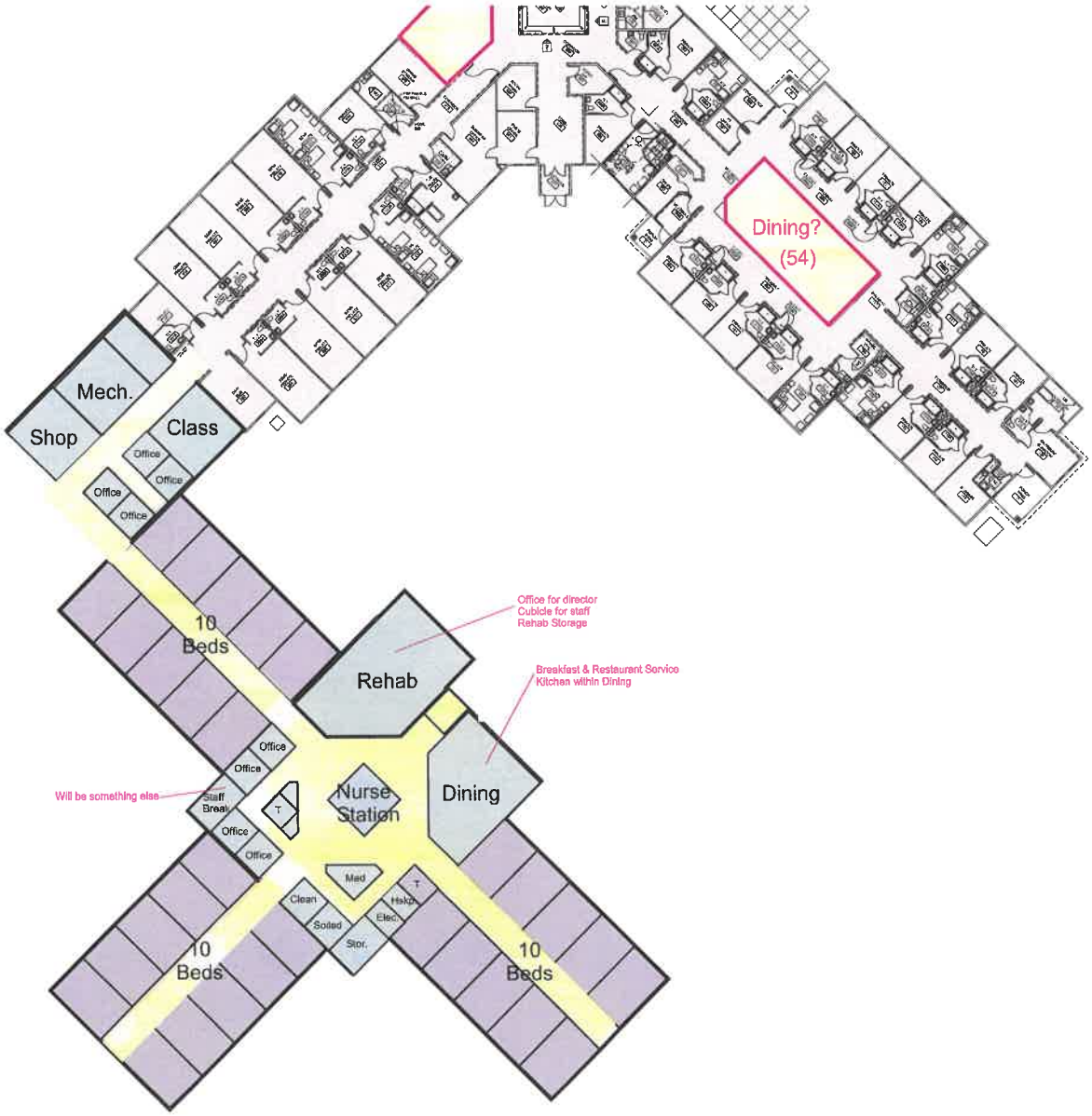
1" = 70'

0 70

Suncrest Healthcare Communities

Saint Albans, VT

e4h ENVIRONMENTS FOR HEALTH ARCHITECTURE



Franklin County Rehab 30 Bed Expansion
Concept Floor Plan

09 May 2023

Suncrest Healthcare Communities
Saint Albans, VT

e4h ENVIRONMENTS FOR HEALTH ARCHITECTURE

Attachment: Question 11

"In the spirit of community"
Franklin County
Rehab Center, LLC

Franklin County Rehab and Adult Care Center
110 Fairfax Road, St. Albans, VT 05478 • Ph. (802) 752-1600 • Fax. (802) 752-1666

11. Provide the Centers for Medicare and Medicaid's (CMS) overall star ratings for The Villa and for FCRC for the most recent three-year period.

Suncrest Healthcare Communities 5 Star Rating		
Date by Qtr. & Current	Franklin County Rehab Center	Villa Rehab Center
May, 2023	5	5
Mar, 2023	3	5
Dec, 2022	3	4
Sep, 2022	3	4
Jun, 2022	4	5
Mar, 2022	4	5
Dec, 2021	4	5
Sep, 2021	4	4
Jun, 2021	5	4
Mar, 2021	5	4
Dec, 2020	5	5
Sep, 2020	5	5
Jun, 2020	5	5

Attachment: Question 12- Villa

VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

December 11, 2019

Ms. April Furlow, Administrator
The Villa Rehab
7 Forest Hill Drive
St Albans, VT 05478-1615

Dear Ms. Furlow:

Enclosed is a copy of your acceptable plans of correction for the State portion of the Re-certification survey conducted on **November 20, 2019.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475055	A. BUILDING: _____ B. WING _____	11/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA REHAB	7 FOREST HILL DRIVE ST ALBANS, VT 05478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S208	Continued From page 1 hours to the licensing agency: This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to report to the licensing agency an untimely death, as a result of an untoward event (such as an accident/fall), for one applicable resident, (Resident #20). The findings include the following: Per review of the medical record, Resident #20 has diagnoses of, but not limited to, Dementia, Alzheimer's Disease, Congestive Heart Failure and Fracture of the 10th rib right side. An incident report dated 09/12/19 at 06:57 AM, identifies that the resident fell from his/her bed. Per interview with the Licensed Nurse Aide on 11/19/19 at approximately 1 PM, s/he confirms that the fall was some 25-30 inches from the height of the bed to the floor. A portable x-ray of the chest and bilateral ribs was obtained on 09/20/19 that identified a fractured lateral right 10th rib with moderate cadiomegaly (an enlarged heart). The resident died on 09/21/19 at approximately 9:30 PM, seven days after the fall. The Office of Medical Examiner's determined the cause of death to be Congestive Heart Failure secondary to rib fracture caused by blunt force trauma as a contributing factor. Confirmation was made on 11/19/19 at approximately 3 PM that a report was not made to the licensing agency. However, the Nursing Home Administrator acknowledges that the Medical Examiner was notified at the time of death 09/21/19 and did review the medical record two days after the death.	S208		

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury VT 05671-2060
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To Report Adult Abuse: (800) 564-1612

January 17, 2019

Ms. April Furlow, Administrator
The Villa Rehab
7 Forest Hill Drive
St Albans, VT 05478-1615

Provider ID #: 475055

Dear Ms. Furlow:

On **January 9, 2019**, we conducted a revisit to the survey of **November 28, 2019** to verify that your facility had achieved substantial compliance. Based on our revisit, we found that your facility is in substantial compliance with participation requirements found in Title 42, Code of Federal Regulations as of **December 11, 2018**.

If you have any questions concerning this letter please contact me at (802) 241-0480.

Sincerely,

Pamela Cota, RN
Licensing Chief

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury VT 05671-2060
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To Report Adult Abuse: (800) 564-1612

May 26, 2022

Ms. April Furlow, Administrator
The Villa Rehab
7 Forest Hill Drive
St Albans, VT 05478-1615

Provider ID #: 475055

Dear Ms. Furlow:

The Division of Licensing and Protection completed a recertification survey at your facility on **May 25, 2022**. The purpose of the survey was to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare/Medicaid programs.

This survey found that your facility was in substantial compliance with the participation requirements. Congratulations to you and your staff.

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

Enclosure

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475055	A. BUILDING _____ B. WING _____	05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA REHAB	7 FOREST HILL DRIVE ST ALBANS, VT 05478

(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 review of the facility's Emergency Preparedness Program was conducted in conjunction with the annual recertification survey on 5/25/2022. There were no regulatory deficiencies as a result of the review.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite recertification survey and staff vaccination requirement review was conducted by the Division of Licensing and Protection from 5/23- 5/25/2022. As a result of the survey, the facility was found to be in substantial compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: April Fuller | TITLE: Nursing Home Administrator | (X6) DATE: 5/26/22

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.

Attachment: Question 12-FCRC

VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
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Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612December 21, 2022

January 3, 2022

Ms. Coleen Condon, Administrator
Franklin County Rehab Center Llc
110 Fairfax Road
St Albans, VT 05478-6299

Provider ID #: 475047

Dear Ms. Condon:

The Division of Licensing and Protection completed a survey at your facility on **December 21, 2022**. The purpose of the survey was to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare/Medicaid programs.

This survey found that your facility was in substantial compliance with the participation requirements.

Congratulations to you and your staff.

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

Enclosure

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475047	A. BUILDING _____ B. WING _____	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY REHAB CENTER LLC	110 FAIRFAX ROAD ST ALBANS, VT 05478

(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 review of the facility's Emergency Preparedness Program was conducted in conjunction with the annual recertification survey on 12/21/22. There were no regulatory deficiencies as a result of the review.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite recertification survey and staff vaccination requirement review was conducted by the Division of Licensing and Protection from 12/19/22 to 12/21/22. As a result of the survey, the facility was found to be in substantial compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Coleen Condon
TITLE: Administrator/owner
(X6) DATE: 1/3/2023

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.

Division of Licensing and Protection
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To Report Adult Abuse: (800) 564-1612

February 4, 2022

Ms. Coleen Kohaut, Administrator
Franklin County Rehab Center Llc
110 Fairfax Road
St Albans, VT 05478-6299

Provider ID #: 475047

Dear Ms. Kohaut:

On **February 1, 2022**, we conducted a revisit to the survey of **December 1, 2021** to verify that your facility had achieved substantial compliance. Based on our revisit, we found that your facility is in substantial compliance with participation requirements found in Title 42, Code of Federal Regulations as of **December 23, 2021**.

If you have any questions concerning this letter please contact me at (802) 241-0480.

Sincerely,

Pamela M Cota RN

Pamela Cota, RN
Licensing Chief

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475047	A. BUILDING _____ B. WING _____	R 02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY REHAB CENTER LLC	110 FAIRFAX ROAD ST ALBANS, VT 05478

(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 An unannounced onsite emergency preparedness survey was completed by the Division of Licensing and Protection from 11/29/-12/1/21. The facility was found in substantial compliance with emergency preparedness regulations.	{E 000}		
{F 000}	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite revisit survey at the facility on the date indicated in the upper right hand corner of this form. The violation(s) previously identified have been corrected.	{F 000}		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Coleen Condon Kohaut
TITLE: Owner / Administrator
(X6) DATE: 2/16/22

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other
ards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the
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
nese documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

December 30, 2021

Ms. Coleen Kohaut, Administrator
Franklin County Rehab Center Llc
110 Fairfax Road
St Albans, VT 05478-6299

Dear Ms. Kohaut:

Enclosed is a copy of your acceptable plans of correction for the recertification survey and complaint investigation completed on **December 1, 2021.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475947	A. BUILDING _____ B. WING _____	C 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY REHAB CENTER LLC	118 FAIRFAX ROAD ST ALBANS, VT 05478

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E 000	Initial Comments An unannounced onsite emergency preparedness survey was completed by the Division of Licensing and Protection from 11/29/-12/1/21. The facility was found in substantial compliance with emergency preparedness regulations.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite recertification survey was completed by the Division of Licensing and Protection from 11/29 - 12/1/21. The following regulatory violations were cited as a result of the recertification survey:	F 000		
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: Per staff interview and record review, the facility failed to ensure that the resident assessment accurately reflects the resident's status for two of 21 residents (Resident #7 and Resident #12). 1. Per review of the MDS (minimum data set) assessment from 6/9/21, Resident #7 was marked as having had a UTI (urinary tract infection) in the last 3 months. Per review of the resident record, Resident #7 had a laboratory confirmed UTI in April of 2021 and was prescribed antibiotics for treatment. Per review of the MDS assessment from 9/8/21, Resident #7 was again marked as having had a UTI in the last 3 months. Review of the resident record did not show any indication of Resident #7 having had a	F 641	F 641 – Accuracy of Assessments 1. Previous corrective action had previously taken place for the residents affected: Resident #7 MDS for 6/2021 stated correctly that the resident had tested positive for a UTI. MDS for 9/2021 should have removed this finding and did not. This was corrected for the MDS completed on 12/1/2021. Resident # 12 developed a stage 2 in 2/2021. This was coded correctly on the MDS in 3/2021. It was inadvertently left of the 6/2021 MDS although the stage 2 was not healed. On the 9/8/2021 MDS the continued stage 2 was coded correctly and therefore the MDS was correct as of 9/8/2021. Continued	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Colleen Kohaut
TITLE: Administrator/owner
(X6) DATE: 12/20/21

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

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F 641	Continued From page 1 UTI during that time period. Per interview on 11/29/21 at approximately 3:00 PM, the MDS Coordinator confirmed that the documentation of a UTI in the 9/8/21 MDS assessment for Resident #7 was done so in error. 2. Per review of Resident #12's record, Resident #12 has had a small stage 2 pressure ulcer on their right second toe since March of 2021. Weekly skin assessments in the record show that the pressure ulcer has been present since its discovery in March 2021. Per review of the MDS assessment from 6/9/21, Resident #12 was marked as not having any pressure ulcers in the last 3 months. Per interview on 12/1/21 at approximately 11:00 AM, the MDS Coordinator confirmed that the documentation of no pressure ulcers in the 6/9/21 MDS assessment for Resident #12 was done so in error.	F 641	2. Identification of other residents having the potential to be affected by the MDS coordinator and was determined that all residents have the potential to be affected. 3. Education was provided to the MDS staff addressing the importance of the accuracy of the MDS. 4. The MDS staff will conduct a random audit of 2 residents per week for a review of the accuracy of the MDS. Findings of the audits will be discussed at QAPI. This will continue for a period of 4 weeks. If substantial compliance has been met the random audit of 2 residents will then be performed monthly for a period of 5 months. Audits will end if substantial compliance continues to be met.	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to– (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657	Date of Completion: 12/20/2021 Tag F641 POC accepted on 12/29/21 by L. Lovell LNHA RN F657 see next pg.	

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F 657	Continued From page 2 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (ii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to review and revise Care Plans related to fall prevention for 3 residents [Res. #42, #22, and #40] of 21 sampled residents. Findings include: 1). Per record review, Res. #42 was admitted to the facility on 10/27/21 with diagnoses that include dementia and a history of falls and weakness. Progress notes record the resident requires 'a maximum assist of two to three persons for turning, repositioning in bed and transfers with mechanical lift and three persons. Admitted for worsening dementia with possible Long Term Care placement due to increased need for 24 hour a day care.' Progress notes also record 'Alert and oriented to self only ...Lives in her own world. Fall risk'. On the day of his/her admission, Res. #42's Care Plan was initiated and identified the resident as 'at risk for falls related to a history of several recent falls at home, confusion and impulsivity. His/her fall risk score upon admission = 17,	F 657	F 657 – Care Plan Timing and Revision 1. Corrective action taken for the residents found to have been affected include: The MDS coordinator updating the care plan for Residents #42, #22, #40. 2. Identification of other residents having the potential to be affected by the MDS coordinator / Charge Nurse and was determined that all residents have the potential to be affected. 3. The Staff Development Nurse provided the LTC & Rehab Charge Nurse as well as the MDS department education regarding the importance of fall prevention and intervention as well as how to properly update the care plan following a fall. Continued	

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F 657	Continued From page 3 indicating a high risk for falls.' An interview was conducted with the Director of Nursing [DON] and the Long Term Care Unit Manager [LTC UM] on 12/01/21 at 1:00 PM. The DON and LTC UM stated that a fall risk assessment should be completed as soon as possible after each fall by a resident, and that a resident's Care Plan should be updated/revised with new interventions after each fall. Per review of Res. #42's medical record, on 11/4/21 at 4:30 PM Res. #42 'yelled for help from [h/her] room, upon entering room the resident was observed lying in prone position on floor at the foot of [h/her] bed. Resident was noted to have [h/her] head near the bed and feet towards the wall ...Resident with prior history of falls, has poor safety awareness.' Per record review and confirmed during the interview with the Director of Nursing [DON] and the Long Term Care Unit Manager [LTC UM] on 12/01/21 at 1:00 PM, the DON and LTC UM stated that a fall risk assessment should have been completed after Res. #42 fell on 11/4/21 but was not. The DON and LTC UM further stated that Res. #42's Care Plan should have been reviewed and revised to include additional interventions after the fall on 11/4/21 in order to prevent future falls but was not. 2.) Res. #22 was admitted to the facility with diagnoses that include neoplasm of the brain and seizures. Res. #22's Care Plan, dated 9/11/2020 identified the resident 'at risk for falls related to a history of recent falls, impaired cognition, incontinence, and seizures. [H/she] is a high fall risk.' An interview was conducted with the Director of Nursing [DON] and the Long Term Care Unit Manager [LTC UM] on 12/01/21 at 1:00 PM. The	F 657	4. The MDS staff will conduct a weekly audit of at least one resident care plan who has had a fall that week to ensure that it has been updated to include new interventions per facility policy. This will continue for a period of 4 weeks. If substantial compliance has been met the audit will then be performed monthly for a period of 5 months. Audits will end if substantial compliance continues to be met. Audits will be shared with the QAPI team. Date of Completion: 12/23/2021 Tag F657 PoC accepted 12/24/21 by L. Lovell / D. Lidecombe	

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F 657	Continued From page 4 DON and LTC UM stated that a fall risk assessment should be completed as soon as possible after each fall by a resident, and that a resident's Care Plan should be updated/revised with new interventions after each fall. Per review of Res.#22's medical record, on 7/19/21, 'This RN was called down to [Res. #22's] room at 9:45 AM related to [Res. #22] falling in the bathroom. When this writer entered the bathroom [Res. #22] was sitting on the floor with h/her back against the wall. An LNA found [Res. #22] in h/her bathroom after h/her fall.' A Care Plan note, dated 10/12/21, approximately 3 months after the fall on 7/19/21, records Res. #22 'had a fall on 7/19/21 with no injuries noted. Fall assessments completed per protocol.' Per record review, there was no fall risk assessment completed after Res. #22's fall on 7/19/21. A fall risk assessment dated almost 2 months later, on 9/2/21, records 'History of falls: No falls=0'. Per record review and confirmed during the interview with the Director of Nursing [DON] and the Long Term Care Unit Manager [LTC UM] on 12/01/21 at 1:00 PM, the DON and LTC UM stated that a fall risk assessment should have been completed after Res. #22 fell on 7/19/21 but was not. The DON and LTC UM further stated that Res. #22's Care Plan should have been reviewed and revised to include additional interventions after the fall on 7/19/21 in order to prevent future falls but was not. 3.) Per review of Resident #40's record, Resident #40 sustained falls at the facility on 1/30/21, 4/13/21, 5/28/21, 6/8/21, 8/22/21, 10/12/21, 10/25/21, and 11/3/21. Per review of Resident #40's care plan, there is a care plan focus of '[Resident #40] is at risk for falls related to history of falls, poor safety awareness, and rolling walker recommended for ambulation which [they] often	F 657		

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F 657	Continued From page 5 do not use" initiated on 5/27/19. All interventions under this care plan focus were added to the care plan on 5/27/19. There have been no updates to the care plan interventions since 5/27/19. Per review of the facility's policy Fall Prevention and Post-Fall Protocol, bullet #9 under the section Post fall assessment/instructions states, "Interdisciplinary team will review and revise care plans as necessary after each fall. The team will determine if additional interventions/strategies can minimize or prevent additional [falls]." Per interview on 12/1/21 at approximately 12:00 PM, the Charge Nurse discussed many interventions that have been implemented following Resident #40's repeated falls to try and prevent further falls. These include removing tray tables from the room, 1:1 observation, keeping their bed in the lowest position, and others. The Charge Nurse confirmed that these interventions were not documented in Resident #40's care plan.	F 657		
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	F 758	F758 – Free From Unnecessary Psychotropic Meds/PRN Use 1. Immediate action taken for the resident found to have been affected include: The medication regimen for Resident #40 was reviewed, the medication prescribed for prn anxiety was re-ordered to include a stop date and the medication for major depressive disorder was amended to include a corresponding diagnosis.	

Continued

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F 758	Continued From page 6 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; §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 staff interview and record review, the facility failed to ensure a resident's drug regimen is free from unnecessary psychotropic drugs as	F 758	2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. A review of all PRN medication orders and indications for use was completed on 12/6/2021. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: In servicing all licensed nursing staff on the facility policy for Use of Psychotropic Medication along with education regarding medication admin. Physicians were provided a copy of the facility policy. 4. The corrective action will be monitored to ensure the error will not recur: The DNS or designee will complete random weekly audits for four weeks of new prn medication orders to ensure that appropriate indications and stop dates for use of any prn psychotropic medications are clearly documented in the medical record. Audits will end if substantial compliance continues to be met. Audits will be shared with the QAPI team. Date of Completion: 12/23/2021	

Tag F 758
POC accepted
on 12/29/21
by L. Lovell & Widamaker RN

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 758	Continued From page 7 evidenced by drugs used without adequate indications for use and PRN (as needed) drugs used without a defined duration for one of 5 sampled residents (Resident #40). Findings include: 1. Per review of Resident #40's MAR (medication administration record), Resident #40 was ordered PRN Ativan (a medication for anxiety) and scheduled Olanzapine (an antipsychotic). The Ativan order placed on 11/15/21 reads, "Ativan 0.5 mg tablet - give one tablet by mouth every 6 hours as needed for anxiety/agitation." There is no designated end date or duration ordered for this medication. The Olanzapine order placed on 6/10/21 reads, "Olanzapine 10mg tablet - give one tablet by mouth every morning." There is no indication in the order of what specific condition or diagnosis the Olanzapine is ordered to treat. Per interview on 12/1/21 at approximately 2:00 PM, the Director of Nursing confirmed that the Olanzapine and PRN Ativan orders do not meet the regulatory requirements for psychotropic medications.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812	See next pg.	

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F 812	Continued From page 8 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to store food and drink in accordance with professional standards for food service safety as evidenced by the presence of expired food items and opened perishable food items without proper storage. Findings include: 1. Per observation on 11/29/21 at approximately 10:00 AM, the front kitchen fridge contained an opened bottle of thickened orange juice. There was no open date written on the bottle. The manufacturer's instructions on the bottle instructs the user to discard the contents within 10 days of opening. Per interview with the Dietary Manager at the time of observation, the Dietary Manager confirmed that this bottle was not labeled with an open date. Per observation on 11/30/21 at approximately 12:30 PM, the long-term care unit nourishment kitchen fridge contained the following items: - An unopened single-serve container of yogurt with an expiration date of 11/22/21. - An opened bottle of thickened orange juice without an open date written on the bottle and	F 812	F812 – Food Procurement Store/Prepare/Serve-Sanitary 1. Immediate action taken included discarding any expired or not dated items. 2. The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: In servicing all kitchen staff on the importance of checking all refrigerators daily for expired / non dated items and discarding such items. Signage has also been placed on refrigerators reminding all staff to date any opened items. 4. The corrective action will be audited weekly by the dietary manager for a period of four weeks. Audits will end if substantial compliance continues to be met. Date of Completion: 12/21/2021 Tag F812 POC accepted on 12/29/21 by L. Lovell/Plunkett	

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FRANKLIN COUNTY REHAB CENTER LLC	118 FAIRFAX ROAD ST ALBANS, VT 05478

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F 812	Continued From page 9 manufacturer's instructions on the bottle to discard the contents within 10 days of opening. - An opened bottle of thickened water without an open date written on the bottle and manufacturer's instructions on the bottle to discard the contents within 10 days of opening. - An opened bottle of a resident's personal vegetable juice without an open date written on the bottle and manufacturer's instructions on the bottle to discard the contents within 14 days of opening. Per observation on 11/30/21 at approximately 12:40 PM, the rehab unit nutrition fridge contained an opened bottle of apple juice without an open date on the bottle and manufacturer's instructions on the bottle to discard the contents within 14 days of opening. Per interview on 11/30/21 at approximately 12:45 PM, the Dietary Manager confirmed the presence and condition of these food items. Per review of the facility's policy Date Marking for Food Safety, the policy states, "2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. 3. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared." Per interview on 11/30/21 at approximately 3:30 PM, the Dietary Manager confirmed that the observed expired/unlabeled food and drink items were not stored appropriately.	F 812		

Attachment: Question 13- Villa

VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line (888) 700-5330
To Report Adult Abuse: (800) 564-1612

June 8, 2023

Ms. April Furlow, Administrator
The Villa Rehab
7 Forest Hill Drive
St. Albans, VT 05478-1615

Provider ID #: 475055

Dear Ms. Furlow:

On **April 13, 2023**, the Vermont Department of Public Safety, Division of Fire Safety conducted a revisit to the Centers for Medicaid and Medicare Services (CMS) Federal Monitoring Survey that was conducted on **July 28, 2022**, to verify that your facility had achieved substantial compliance. The revisit revealed that substantial compliance has been achieved as tag K-0161- Building Construction Type and Height has been approved for a Time Limited Waiver to correct this deficiency that will expire on **October 31, 2023**.

If you have any questions, please feel free to contact this office.

Sincerely,

tammy wehmeyer

Tammy Wehmeyer
Administrative Services Manager

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475055	A. BUILDING 01 B. WING	R 04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA REHAB	7 FOREST HILL DRIVE ST ALBANS, VT 05478

(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 An Emergency Preparedness (EP) and a Life Safety Code (LSC) comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on July 28, 2022, following a Vermont Division of Licensing and Protection State Fire Marshal, Vermont State survey agency survey, that was conducted on May 31, 2022. At this comparative Federal Monitoring Survey The Villa Rehabilitation, CCN 475055, was found in substantial compliance with the requirements for participation in Medicare/Medicaid, 42 CFR, Subpart 483.73 Emergency Preparedness. The building is described in the K000 section for the Life Safety Code survey. Emergency backup power to the building was supplied by a 50KW propane generator outside the facility. The facility generator is stated to be fully tied to the building including the fire alarm control panel, outlets, lights and life safety components utilized for preservation of life. The facility is approximately 1.5 miles from a local paid and volunteer fire department. The facility did not admit residents on life support and stated they do not typically admit bariatric residents. The facility has a capacity of 30 beds with a census of 17 at the time of the survey. The requirement at 42 CFR Subpart 483.73 is MET as evidenced by:	{E 000}		
{K 000}	INITIAL COMMENTS The Vermont Division of Fire Safety conducted an unannounced, onsite revisit survey on April 23, 2023, to the Centers for Medicare and Medicaid Services (CMS) Federal Monitoring Survey that	{K 000}		

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475055	A. BUILDING 01 B. WING _____	R 04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA REHAB	7 FOREST HILL DRIVE ST ALBANS, VT 05478

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{K 000}	Continued From page 1 was conducted on July 29, 2022. Inspection revealed that K-161-Building Construction Type And Height remains out of compliance.	{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) 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	{K 161}		

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

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{K 161}	Continued From page 2 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 interview, the facility is a three story building of a construction type not permitted to be over one story and not permitted to be partially sprinkler protected in accordance with LSC Section 19.1.6.1, 19.1.6.2. through 19.1.6.7. The deficient practice could affect 17 of 17 residents, as well as an indeterminable number of staff and visitors. Findings Include: Interview on 07/28/2022 at approximately 11:30am during the facility entrance conference/record review with the facility Administrator and Associate Administrator identified the nursing home as a three story building, with a basement and attic (attic storage loft open to third floor), wood construction. Per interview, the floors were identified as ground floor/first floor-primary level of exit discharge, second floor, and third floor with residents residing on the first floor and second floor and administrative offices on the third floor. Per interview on 07/28/2022 at approximately 11:30am with the Administrator and Associate Administrator, the building was constructed in 1863 as a residential house converted to a nursing home in the 1960s with minor cosmetic renovations over the years, and hall 3 was added in the 60's. Observation of the building on	{K 161}		

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

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{K 161}	Continued From page 3 07/28/2022 from 2:00pm to 4:00pm during the facility tour identified and verified the building as combustible wood stud construction, gypsum/plaster, Type V(000) construction. Observation on 07/28/2022 at approximately 2:30pm at the third floor storage area and open loft to the storage area above the third floor was exposed wood stud construction. Observation on 07/28/2022 at approximately 3:45pm of the basement floor level was exposed wood construction. In addition, at approximately 3:30pm during the facility tour identified the exterior overhang that exceeded 4' on the ground/first floor south side exit was not sprinkler protected (see K351). The findings were verified by the Administrator and Associate Administrator at the times of observation.	{K 161}		

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

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	475055	A. BUILDING _____ B. WING _____	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA REHAB	7 FOREST HILL DRIVE ST ALBANS, VT 05478

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E 000	Initial Comments An Emergency Preparedness (EP) and a Life Safety Code (LSC) comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on July 28, 2022, following a Vermont Division of Licensing and Protection State Fire Marshal, Vermont State survey agency survey, that was conducted on May 31, 2022. At this comparative Federal Monitoring Survey The Villa Rehabilitation, CCN 475055, was found in substantial compliance with the requirements for participation in Medicare/Medicaid, 42 CFR, Subpart 483.73 Emergency Preparedness. The building is described in the K000 section for the Life Safety Code survey. Emergency backup power to the building was supplied by a 50KW propane generator outside the facility. The facility generator is stated to be fully tied to the building including the fire alarm control panel, outlets, lights and life safety components utilized for preservation of life. The facility is approximately 1.5 miles from a local paid and volunteer fire department. The facility did not admit residents on life support and stated they do not typically admit bariatric residents. The facility has a capacity of 30 beds with a census of 17 at the time of the survey. The requirement at 42 CFR Subpart 483.73 is MET as evidenced by:	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: April Purdue, NHA | TITLE | (X6) DATE: 8/8/22

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	(XJ) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475055	A. BUILDING 01 - **BUILDING 01** B. WING	**07/28/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA REHAB	**7 FOREST HILL DRIVE** **ST ALBANS, VT 05478**

(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 A Life Safety Code (LSC) comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on July 28, 2022, following a Vermont Division of Licensing and Protection State Fire Marshal, Vermont State survey agency survey, that was conducted on May 31, 2022. At this comparative Federal Monitoring Survey The Villa Rehabilitation, CCN 475055, was found not in substantial compliance with the requirements for participation in Medicare/Medicaid, 42 CFR, Subpart 483.90(a), Life Safety from fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. The facility is determined to be three story, with a basement and attic (attic storage loft open to third floor), combustible construction, Type V(000). The floors were identified as ground floor/first floor-primary level of exit discharge, second floor, and third floor with residents residing on the first floor and second floor and administrative on the third floor. The building was constructed in 1863 as a residential house converted to a nursing home in the 1960s with minor cosmetic renovations over the years, and hall 3 added in the 60's. The building has monolithic ceilings through out with smoke and sprinkler detection at the ceiling. The facility heating was register heating and window air conditioning. The facility smoke detection system is in the corridors tied to the fire alarm control panel. Resident rooms have si»gle station battery operated smoke detectors. The nursing home was fully sprinkler protected	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(XB) DATE
Carol Fuller	NHA	8/15/22

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 (upon correction of K351) with a dry sprinkler system. The sprinkler system is on domestic water with no fire pump. Emergency backup power to the building was supplied by a SOKW propane generator outside the facility. The facility generator is stated to be fully tied to the building including the fire alarm control panel, outlets, lights and life safety components utilized for preservation of life. The facility is approximately 1.5 miles from a local paid and volunteer fire department. The facility did not admit residents on life support and stated they do not typically admit bariatric residents. The facility has a capacity of 30 beds with a census of 17 at the time of the survey. The requirement at 42 CFR Subpart 483.90(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	K 161	We are requesting an extension of 3 to 4 weeks on this one deficiency due to the complexity of it. This will allow time to evaluate and learn what needs to be done to become compliant or to file an IDR if necessary.	

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	475055	A. BUILDING 01 - BUILDING 01 B. WING _____	07/28/2022

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K 161	Continued From page 2 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH)' 6 V (111) 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 Based on observation and interview, the facility is a three story building of a construction type not permitted to be over one story and not permitted to be partially sprinkler protected in accordance with LSC Section 19.1.6.1, 19.1.6.2. through 19.1.6.7. The deficient practice could affect 17 of 17 residents, as well as an indeterminable number of staff and visitors. Findings include: Interview on 07/28/2022 at approximately 11:30am during the facility entrance conference/record review with the facility Administrator and Associate Administrator	K 161		

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K 161	Continued From page 3 identified the nursing home as a three story building, with a basement and attic (attic storage loft open to third floor), wood construction. Per interview, the floors were identified as ground floor/first floor-primary level of exit discharge, second floor, and third floor with residents residing on the first floor and second floor and administrative offices on the third floor. Per interview on 07/28/2022 at approximately 11:30am with the Administrator and Associate Administrator, the building was constructed in 1863 as a residential house converted to a nursing home in the 1960s with minor cosmetic renovations over the years, and hall 3 was added in the 60's. Observation of the building on 07/28/2022 from 2:00pm to 4:00pm during the facility tour identified and verified the building as combustible wood stud construction, gypsum/plaster, Type V(000) construction. Observation on 07/28/2022 at approximately 2:30pm at the third floor storage area and open loft to the storage area above the third floor was exposed wood stud construction. Observation on 07/28/2022 at approximately 3:45pm of the basement floor level was exposed wood construction. In addition, at approximately 3:30pm during the facility tour identified the exterior overhang that exceeded 4' on the ground/first floor south side exit was not sprinkler protected (see K351). The findings were verified by the Administrator and Associate Administrator at the times of observation.	K 161		
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits	K 271	What corrective action will be accomplished for those residents found to have been affected? City permits have been filed with the city clerk and plans have been drafted to install a hard packed path or sidewalk. The installation will be completed on or before September 15, 2002.	

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K 271	Continued From page 4 Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide discharge from exits that were a level walking surface of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38, LSC 7.7, 7.1.7 and 19.2.7. This deficient practice could affect exiting from three smoke compartments, 7 residents, as well as an indeterminable number of staff. Findings Include: 1. Observation on 07/28/2022 at approximately 3:30pm during the facility tour identified the facility designated exit (exit sign above the door) from the ground/first floor on the south side of the building exited to an open metal grate walking surface exit with open metal grate step treads (steps that were not secured to the ground or building) with no hard path to the public way. The exit discharge pathway was across an uneven slope covered with grass and trip hazards. Interview at the time of observation with the Administrator and Associate Administrator confirmed there was no hard path to the public way. 2. Observation on 07/28/2022 at approximately 3:45pm during the facility tour identified the facility designated exit (exit signs above the doors) from	K 271	How will you identify other resident having the potential to be affected by the same deficient practice? The proposed actions will eliminate any resident's current or future from being affected by the alleged deficient practice, as all exits will have a hard path to public way. What measure will be put into place or what systemic changes you will make to ensure the deficient practice does not recur? All exits have been addressed and will have hard paths to public way. How the corrective action will be monitored to ensure the deficient practice will not recur? Policies have been established to ensure all exits have a hard path to public way.	

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K 271	Continued From page 5 the third and second floor smoke zones on the south east side of the building exited to wood covered exit stairway with no hard path to the public way. The exit discharge pathway was across an uneven slope covered with grass and trip hazards. Interview at the time of observation with the Administrator and Associate Administrator confirmed there was no hard path to the public way. The findings were verified by the Administrator and Associate Administrator at the times of observation.	K 271		
K 345 SS=C	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain the documentation of the sensitivity testing for the smoke detective devices tied to the fire alarm control panel in accordance with NFPA 72, 2010 Edition, Section 14.4.5.3 and LSC Section 9.6.1.3, 9.6.1.5 and 9.6.1.7. This deficient practice could affect all smoke zones, 17 of 17 residents, and an indeterminable number of staff and visitors. Findings Include:	K 345	What corrective action will be accomplished for those residents found to have been affected? Facility vendor will perform sensitivity testing along regular preventative maintenance. Sensitivity testing will be complete no later than November 01, 2022. How will you identify other resident having the potential to be affected by the same deficient practice? All residents have the potential to be affected by this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur? Maintenance Director and NHA will ensure fire alarm vendor is scheduled to complete sensitivity testing with regular fire alarm testing annually and keep records of documented testing.	

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THE VILLA REHAB	**7 FOREST HILL DRIVE** **ST ALBANS, VT 05478**

(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)	(:::6) COMPLETION DATE
K 345	Continued From page 6 Record review on 07/28/2022 at approximately 11:30am identified records from Alarmco dated 10/12/2021, 09/11/2020, 06/01/2019, and 09/18/2018 documented no sensitivity testing for a zone system (15 identified smoke detectors) with no documentation showing a sensitivity test being conducted. In addition, documentation identified the number of devices varied from 09/18/2018 to 10/12/2021 with the number of heat detectors being reduced from 4 to 3, carbon monoxide detectors being reduced from 5 to 2, door hold open devices being reduced from 9 to 4 and horns/strobes being reduced from 7 to 6 with no documentation of why items for safety were removed. Interview on 07/28/2022 with the Administrator and Associate Administrator at the time of record review confirmed the finding. The finding was verified by the Administrator and Associate Administrator at the time of record review.	K 345	How will the corrective action be monitored? Maintenance Director and NHA will Collaboratively audit vendor activity and documentation to ensure sensitivity testing is completed as needed.	
K351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area	K351	What corrective action will be accomplished for those residents found to have been affected? Sprinkler vendor is scheduled to be onsite on 8/15/22 to install a new sprinkler head to said location. What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur? NHA, AIT and Vendor will complete walk-through of facility to ensure there are no other areas that may require additional sprinkler heads, quarterly and as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475055	A. BUILDING 01 - BUILDING 01 B. WING _____	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA REHAB	7 FOREST HILL DRIVE ST ALBANS, VT 05478

(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)	(xs) COMPLETION DATE
K351	Continued From page 7 of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide sprinkler protection for one overhang that exceed 4' in accordance with 42 CFR 483.90(a)(6)(i), NFPA 13, 2010 Edition, Section 8.15.7, LSC Section 19.3.5.1, 19.3.5.4 and 9.7.1.1. The deficient practice could affect one smoke zone, 3 residents, as well as an indeterminable number of staff and visitors. Findings Include: Observation on 07/28/2022 at approximately 3:30pm during the facility tour identified the an exterior overhang at the first floor exit on the south side of the building measuring over 4' by 4' with combustible material (siding and ceiling) was not sprinkler protected. Interview with the Administrator and Associate Administrator at the time of observation confirmed that there was no identified sprinkler to the exterior overhang and confirmed the wood combustible roof structure over the overhang. The finding was verified by the Administrator and Associate Administrator at the time of observation.	K351		
K 353 SS=C	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing	K 353	What corrective action will be accomplished for those residents found to have been affected? NHA worked with vendor R&R and has contracted for quarterly maintenance and testing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475055	A. BUILDING 01 - BUILDING 01 B. WING	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA REHAB	7 FOREST HILL DRIVE ST ALBANS, VT 05478

(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)	(x) COMPLETION DATE
K 353	Continued From page 8 Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to document sprinkler maintenance in accordance with NPFA 101, 2012 edition Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, and NFPA 25, 2011 Edition, Section 5.1. The deficient practice could affect 17 of 17 residents, as well as an indeterminable number of staff and visitors. Findings Include: Record review on 07/28/2022 from approximately 11:30am to 1:00pm identified the facility only had documentation by R and R Sprinkler annually. Record review identified records from R and R Sprinkler dated 07/14/2022 and 07/08/2021. No quarterly inspections were conducted. Interview on 07/28/2022 at approximately 12:00pm at the time of record review, with the Administrator and	K 353	For sprinkler systems. R &R will complete 2 more quarters before year end in addition to the annual inspection that was just done in July. What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur? NHA and Maintenance Director will complete monthly contract vendor audits to ensure preventative maintenance vendors have completed tasks according to schedules.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475055	A. BUILDING 01 - BUILDING 01 B. WING	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA REHAB	7 FOREST HILL DRIVE ST ALBANS, VT 05478

(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)	(xs) COMPLETION DATE
K 353	Continued From page 9 Associate Administrator stated that the facility has never done quarterly sprinkler inspections. The findings were verified by the Administrator and Associate Administrator at the time of record review.	K 353		
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to conduct fire drills at varied times and dates in accordance with LSC Sections 19.7.1.4 through 19.7.1.7. This deficient practice could affect 17 of 17 residents, as well as an indeterminable number of staff and visitors. Findings Include: Record review on 07/28/2022 at approximately 11:30am to 1:00pm identified no fire drills were conducted for the 3:00pm to 11:00pm shift from September 2021 through February 2022. Documentation showed a fire drill conducted on 11/17/2021 at 3:30am and on 12/14/2021 at	K 712	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? NHA and Maintenance Director have started a PIP to ensure accurate and appropriate timing of all fire drills going forward. What measure will be put into place or what systemic changes will make to ensure that the deficient practice does not reoccur? NHA and Maintenance Director will compare and track monthly fire drills to ensure time guidelines are met for each shift quarterly and at varying times. How the corrective action will be monitored. NHA and Maintenance Director will review times and dates of all fire drills each month, prior to schedule next drill.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475055	A. BUILDING 01 - BUILDING 01 B. WING	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA REHAB	7 FOREST HILL DRIVE ST ALBANS, VT 05478

(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 712	Continued From page 10 6:00am. If the fire drill for 11/17/2021 was conducted at 3:30pm instead of 3:30am, it would result in three of four fire drills being conducted between 3:30 and 3:45 (not varied times). In addition, record review identified the fire drill dated 08/30/2021 had no time documented, noting that during the pandemic, actual fire drills were allowed to be replaced with in-service training without movement provided they were documented. Interview on 07/28/2022 at approximately 11:30am at the facility entrance conference with the facility Administrator, stated that the facility has three shifts and stated the shifts are 7:00am to 3:00pm, 3:00pm to 11:00pm and 11:00pm to 7:00am. The findings were verified with the Administrator and Associate Administrator at the time of record review.	K 712		

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Room 2275
Government Center
Boston, Massachusetts 02203

CENTERS FOR MEDICARE & MEDICAID SERVICES

IMPORTANT NOTICE - PLEASE READ CAREFULLY

(This notice is sent via electronic transmission)

March 8, 2023

April Furlow
Administrator
The Villa Rehabilitation
7 Forest Hill Drive
St. Albans, VT 05478
Submitted via email to: afurlow@suncresthcc.com

RE: CMS Certification Number (CCN): 225055

Dear Ms. Furlow,

The request to use the Fire Safety Evaluation System (FSES) for Health Care Occupancies (NFPA 101A, 2013 Edition, Chapter 4) to show an equivalent level of compliance is approved, however the FSES was not passing without correction of outstanding deficiencies meeting all NFPA requirements and the consultant provided suggestions to achieve a passing FSES. Per information provided with the September 27, 2022 and November 28, 2022 FSESs, the facility is failing all zones and did not pass the mandatory table 4.7.10 Parameter H for combustibility of interior finishes (FSES scored interior finishes as Class C). As a result, the information in the FSES is being used to advance the time limited waiver submitted and to approve a waiver for K161 to expire October 31, 2023.

In order to achieve a passing score on the FSES, corrections of all outstanding deficiencies are required or a plan to achieve passing scores for the FSES (if time limited waivers are requested to achieve a passing FSES score). At the time of the FSES (last dated November 28, 2022), your facility is scored as failing the FSES. The FSES is an equivalency, not a waiver. This means when an FSES is conducted and scored correctly, the agent that performed the FSES is attesting to the fact that your facility meets the equivalent level of safety as the prescriptive code. The FSES was submitted for K161.

An Additional Note: This FSES scored zone 2 only as meeting Limited Mobility vs. Not Mobile. Any patient that meets NFPA 101A, 2013 Edition, Section 4.5.1.1 would nullify the FSES occupancy risk parameter factor "R" value. In addition, the FSES scored Safety Parameters 2 and 3 as having Class C flame spread ratings of interior finishes. If the facility has no documentation of the flame spread ratings, the interior finishes cannot be scored (there are other ratings). Any inaccurate information provided would nullify this approval.

The FSES as it was reviewed identified all zones as failing the required Parameter H (worksheet 4.7.10). The zones are identified as following:

Building #01 (Building V(000))
Zone 1, 1st floor, passed except for required Parameter H.
Zone 2, 1st floor, passed except for required Parameter H (scored as limited mobility only).
Zone 3, 1st floor, passed except for required Parameter H.
Zone 4, 2nd floor, failed Containment Safety, Extinguishment and required Parameter H.
Zone 5, 3rd floor, failed Containment Safety, Extinguishment and required Parameter H.
Zone 6, Basement floor, failed Containment Safety, Extinguishment, People Movement and General Safety.

The scores on the FSES can change. Therefore, the FSES must be modified and corrected any time there is a change that would have an impact on your FSES, or at the time of any survey. As corrections are made, the scores on the FSES can change. Therefore, the FSES must be modified and corrected any time there is a change that would have an impact on your FSES, or at the time of any survey.

With the LSC time limited waiver, the provider is submitting information as an assurance to mitigate potential risk during the period in which the work needed for the waiver is to be completed. Please closely monitor the work to ensure correction is being addressed timely. The waiver does not eliminate these deficiencies, it provides a "waiver" of the regulation for the specific period of time requested to allow for correction. These requirements will be monitored and re-evaluated on an ongoing basis until corrected to ensure health and safety risks are being addressed. Please see S&C Memo 17-15-LSC.

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-15.pdf

If you have any questions, please feel free to contact me at 617-565-4487 or at Daniel.Kristola@cms.hhs.gov.

Sincerely,

Daniel Kristola,
Life Safety Code Branch

FIRE SAFETY EVALUATION SYSTEM
HEALTH CARE FACILITIES

(NFPA 101A, "Guide on Alternative Approaches to Life Safety" 2013 Edition)

Complete the following worksheets for each fire/smoke zone*.
Where conditions are the same in several zones, one set of worksheets can be used for those zones.
* Fire/smoke zone is a space separated from all other spaces by floors, horizontal exits, or smoke barriers

Step 1 — Complete Cover Sheet using Worksheet 4.7.1.

WORKSHEET 4.7.1 – COVER SHEET

ZONE 1 OF 6 ZONES

First Floor, Zone 1, Public area, NE corner

NAME OF FACILITY	ADDRESS OF FACILITY		
The Villa Rehab	**7 Forest Hill Dr., St. Albans, VT 05478**		
ZONE(S) EVALUATED **1 of 6 - First Floor**			
PROVIDER/VENDOR NO. **EHDanson Associates Architects**	DATE OF SURVEY **September 1, 27, 2022** Revised 11/28 to incorporate JH comments on 11/14.		
SURVEYOR SIGNATURE **Roy Ward** Roy Ward	TITLE **Principal**	OFFICE	DATE
SURVEYOR ID			
FIRE AUTHORITY SIGNATURE	TITLE	OFFICE	DATE

ADDITIONAL COMMENTS:

Recommended additional improvements for increased life safety (not required to meet FSES):
- **Change door from Zone 1 to Zone 2 to 90 minute door.**
  Existing door appears to be rated but no label. Closer and mag holder is in place
- **Change carpet in stair and hallway and areas open to hallway to Class A rated materials.**
  Changes required to complete stairway from upper levels.

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

Step 2 — Determine Occupancy Risk Parameter Factors using Worksheet 4.7.2.
For each Risk Parameter in Worksheet 7.2, select and circle the appropriate risk factor value.
Choose only one for each of the five Risk Parameters.

WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factor Values					
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable	
	Risk Factor	1.0	1.6	(3.2)	4.5	
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30	
	Risk Factor	1.0	1.2	(1.5)	2.0	
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	(1.1)	1.2	1.4	1.6	1.6
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0	1.1	(1.2)	1.5	4.0*
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 Year		65 Years and Over or 1 Year and Younger		
	Risk Factor	1.0		(1.2)		

*A risk factor of 4.0 is charged to any zone that houses patients without any staff in immediate attendance.

Step 3 — Compute Occupancy Risk Factor (F) using Worksheet 4.7.3.
(1) Transfer the circled risk factor values from Worksheet 4.7.2 to the corresponding blocks in Worksheet 4.7.3.
(2) Compute F by multiplying the risk factor values as indicated in Worksheet 4.7.3.

WORKSHEET 4.7.3 - OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	1.5	X	1.1	X	1.2	X	1.2	=	7.6

Step 4 — Compute Adjusted Building Status (R) - Use Worksheets 4.7.4 or 4.7.5.
(1) If building is classified as "NEW" use Worksheet 4.7.4. If building is classified as "Existing" use Worksheet 4.7.5.
(2) Transfer the value of F from Worksheet 4.7.3 to Worksheets 4.7.4 or 4.7.5, as appropriate. Calculate R.
(3) Transfer R to the block labeled R in Worksheet 4.7.9.
(4) In Worksheets 4.7.4 and 4.7.5, results are always rounded up (i.e., 3.2 is rounded to 4.0).

WORKSHEET 4.7.4 ADJUSTED OCCUPANCY RISK FACTOR (NEW)

	F		R
1.0 X		=	

WORKSHEET 4.7.5 ADJUSTED OCCUPANCY RISK FACTOR (EXISTING)

	F		R	
0.6 X	7.6	=	4.5	(5)

Step 5 — Determine Safety Parameter Values using Worksheet 4.7.6.

(1) Select and circle the safety value for each safety parameter that best describes the conditions in the zone.
(2) Choose only one value for each of the 13 parameters.
(3) If two or more appear to apply, choose the one with the lowest point value.

WORKSHEET 4.7.6 – SAFETY PARAMETER VALUES

Safety Parameters	Parameters Values						
1. Construction	Combustible Types III, IV, and V				Non-Combustible Types I and II		
Floor or Zone	000	111	200	211, 2HH	000	111	222, 322, 442
First	(-2)	0	-2	0	0	2	2
Second	-7	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4

2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A			
	(-5(0))	0(3)[f]	3			
3. Interior Finish (Rooms)	Class C	Class B	Class A			
	(-3(1))	1(3)[f]	3			
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	>½ to <1 hour	≥1 hour		
	-10(0)[a]	0	1(0)[a]	(2(1))[a]		
5. Doors to Corridor	No Door	<20 min FPR	≥ 20 min FPR	≥ 20 min FPR and Auto Closure		
	-10	(0)	1(0)[d]	2(0)[d]		

6. Zone Dimensions	Dead End			No Dead Ends >30 ft. and Zone Length Is		
	>100 ft.	>50 ft. to 100 ft.	30 ft. to 50 ft.	>150 ft.	100 ft. to 150 ft.	<100 ft.
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c] (0)[h]	0(0)[h]	(1)
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resistance			
			<1 hr.	≥1 hr. to <2 hr.	≥2 hr.	
	-14	-10	0	(2(0))[e]	3(0)[e]	
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies	
	In Zone	Outside Zone	In Zone	In Adjacent Zone		
	-11	-5	-6	(-2) **Laundry below**	0	
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mechanically Assisted Systems by Zone			
	-5(0)[c]	(0)	3			
10. Emergency Movement Routes	<2 Routes	Multiple Routes			Direct Exit(s)	
	-8	Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)		
		-2	0	(1)	5	
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm			
			W/O F.D. Conn.	W/F.D. Conn.		
	-4		1	(2)		
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces in Zone	
	0(3)[g]	2(3)[g]	3(3)[g]	(4)	5	
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building			
	0	8	(10)			

[a] Use (0) where parameter 5 is -10.

[b] Use (0) where parameter 10 is -8.

[c] Use (0) on floor with fewer than 31 patients (existing buildings only).

[d] Use (0) where parameter 4 is -10.

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200").
For SI Units: 1 ft.² = 0.3048 m²

[f] Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.

[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

[h] Use (0) where zone area ≤ 22,500 ft.² and distance from any point to reach a door in smoke barrier is ≤ 200 ft.

Step 6 — Compute Individual Safety Evaluations using Worksheet 4.7.7.

(1) Transfer each of the 13 circled Safety Parameter Values from Worksheet 4.7.6 to every unshaded block in the line with the corresponding Safety Parameter in Worksheet 4.7.7. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Worksheet 4.7.7 as 1/2 the corresponding value circled in Worksheet 4.7.6.

(2) Add the four columns, keeping in mind that any negative numbers deduct.

(3) Transfer the resulting total values for S1, S2, S3, S4 to blocks labeled S1, S2, S3, S4 in Worksheet 4.7.9 on page 4 of this sheet.

WORKSHEET 4.7.7 - INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-2	-2		-2
2. Interior Finish (Corr. and Exit)	-5		-5	-5
3. Interior Finish (Rooms)	-3			-3
4. Corridor Partitions and Walls	2			2
5. Doors to Corridor	0		0	0
6. Zone Dimensions			1	1
7. Vertical Openings	0		0	0
8. Hazardous Areas	-2	-2		-2
9. Smoke Control			0	0
10. Emergency Movement Routes			1	1
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		4	4	4
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 0	S_2= 12	S_3= 6	S_4= 8

Step 7 — Determine Mandatory Safety Requirement values using Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(1) Using the facility type (i.e., Hospital or Nursing Home), classification (i.e., New, Existing or Rehabilitated) and the floor where the zone is located, circle the appropriate value in each of the three columns found in Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(2) Transfer the three circled values to the blocks marked S_a, S_b, and S_c in Worksheet 4.7.9.

(3) The Mandatory Safety Requirement value for basements are based on the distance of the basement level from the closest level of discharge (See 4.6.1.2 and 4.6.1.3).

WORKSHEET 4.7.8A - MANDATORY SAFETY REQUIREMENTS – NEW HOSPITALS, EXISTING HOSPITALS OR NEW NURSING HOMES

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Existing	New	Existing	New	Existing
1st story	11	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher, but not high rise	18	9	19(16)[a]	6	11(8)[a]	3
High rise	18	17	19(16)[a]	16	11(8)[a]	7

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

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

WORKSHEET 4.7.8B - MANDATORY SAFETY REQUIREMENTS – EXISTING NURSING HOMES

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	(0)	(10)	(0)
2nd story	2	10	2
3rd story	6	14	2
4th story or higher	8	16	2

WORKSHEET 4.7.8C - MANDATORY SAFETY REQUIREMENTS – MAJOR REHABILITATION IN NONSPRINKLERED EXISTING HOSPITALS

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	13	17(14)*	8(5)*
2nd or 3rd story	17	19(16)*	10(7)*
4th story or higher	18	19(16)*	11(8)*

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

Step 8 — Identify Zone Fire Safety Equivalency using Worksheet 4.7.9.
(1) Transfer the three circled values from Worksheet 4.7.8A, 4.7.8B, or 4.7.8C to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.
(2) For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

WORKSHET 4.7.9 - ZONE FIRE SAFETY EQUIVALENCY EVALUATION

							YES	NO
Containment Safety (S_1)	minus	Mandatory Containment (Sa)	≥ 0	S_1 0	S_a 0	C = 0	X	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (Sb)	≥ 0	S_2 12	S_b 10	E = 2	X	
People Movement Safety (S_3)	minus	Mandatory People Movement (Sc)	≥0	S_3 6	S_c 0	P = 6	X	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 8	R 5	G = 3	X	

Step 9 — Evaluate other considerations not previously addressed using Worksheet 4.7.10.
Complete one copy of this separate worksheet for each facility.
For each consideration, select and mark the appropriate column.

WORKSHEET 4.7.10 FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	X		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			X
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	X		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	X		
E.	There are no flue-fed incinerators.	X		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	X		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	X		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.		X	
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.12 and 19.3.5.12.	X		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	X		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.1.	X		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			X

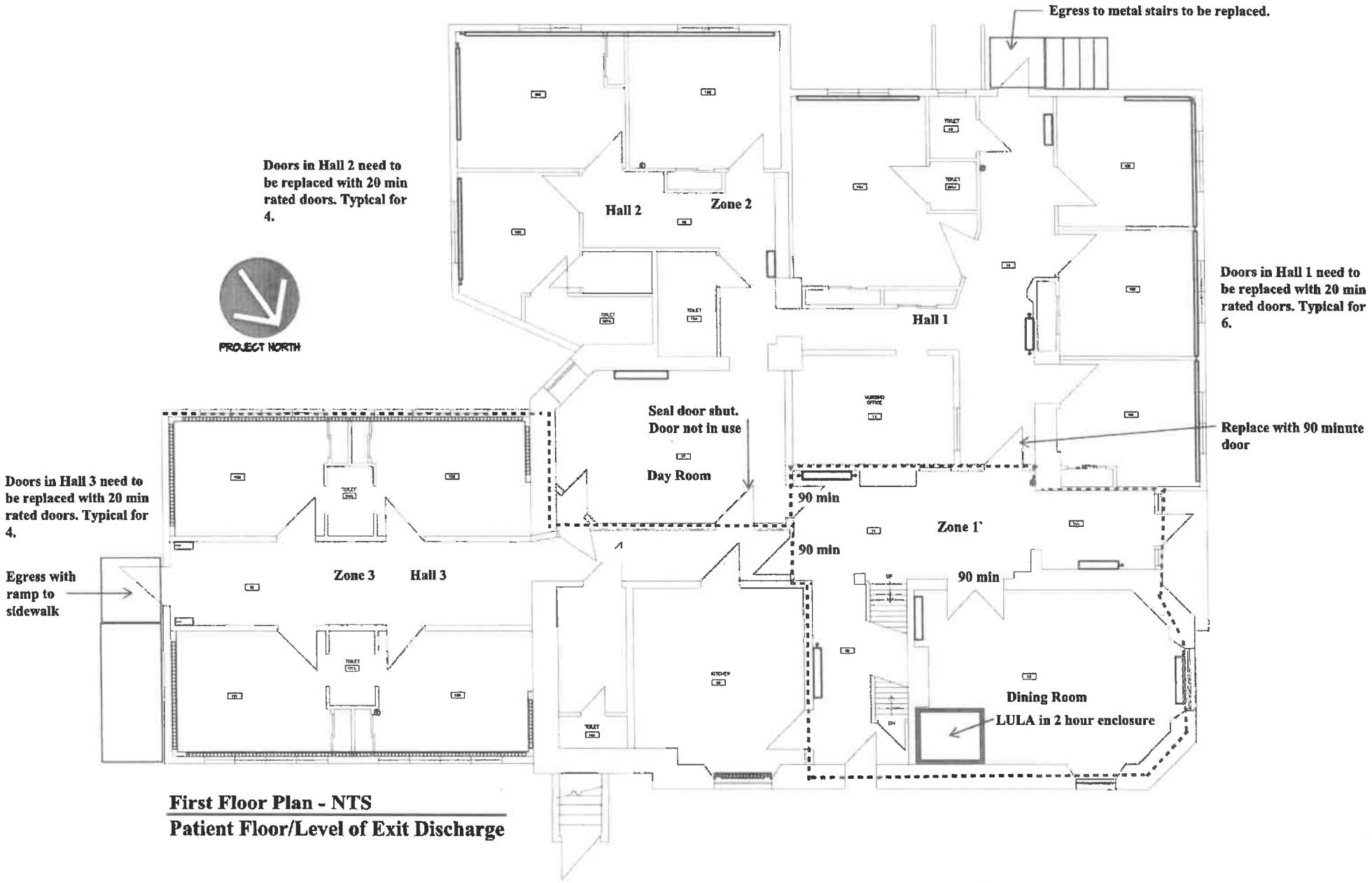
Step 10 — Determine the equivalency Conclusion to determine if the level of life safety is at least equivalent to that prescribed by the Life Safety Code using Worksheet 4.7.11.

WORKSHEET 4.7.11- CONCLUSIONS

1. ☐ All of the checks in Worksheet 4.7.9 are in the "Yes" column and all applicable considerations in Worksheet 4.7.10 are marked as "Met". The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

2. ☒ All of the checks in Worksheet 4.7.9 are in the "Yes" column and all considerations in Worksheet 4.7.10 marked as "Not Met" have been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

3. ☐ One or more of the checks on Worksheet 4.7.9 are in the "No" column or any considerations in Worksheet 4.7.10 marked as "Not Met" have NOT been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is not shown by this system to be equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.



First Floor Plan - NTS

Patient Floor/Level of Exit Discharge

FIRE SAFETY EVALUATION SYSTEM
HEALTH CARE FACILITIES

(NFPA 101A, "Guide on Alternative Approaches to Life Safety" 2013 Edition)

Complete the following worksheets for each fire/smoke zone*.
Where conditions are the same in several zones, one set of worksheets can be used for those zones.
* Fire/smoke zone is a space separated from all other spaces by floors, horizontal exits, or smoke barriers

Step 1 — Complete Cover Sheet using Worksheet 4.7.1.

WORKSHEET 4.7.1 – COVER SHEET

ZONE 2 OF 6 ZONES

First Floor, Zone 2, Hall 1 & 2, NW side

NAME OF FACILITY **The Villa Rehab**	ADDRESS OF FACILITY **7 Forest Hill Dr., St. Albans, VT 05478**		
ZONE(S) EVALUATED **2 of 6 - First Floor**			
PROVIDER/VENDOR NO. **EHDanson Associates Architects**	DATE OF SURVEY **September 1, 27, 2022** Revised 11/28 to incorporate JH comments on 11/14.		
SURVEYOR SIGNATURE **Roy Ward** Roy Ward SURVEYOR ID	TITLE **Principal**	OFFICE	DATE
FIRE AUTHORITY SIGNATURE	TITLE	OFFICE	DATE

ADDITIONAL COMMENTS:

Recommended additional improvements for increased life safety (not required to meet FSES):
- Change corridor doors to 20 minute rated doors with lever hardware and smoke seals.
- Change corridor carpet to Class A rated material or confirm carpet meets that requirement.
- Change louvered bathroom door to 20 minute rated door with lever hardware and smoke seals.

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

Step 2 — Determine Occupancy Risk Parameter Factors using Worksheet 4.7.2.
For each Risk Parameter in Worksheet 7.2, select and circle the appropriate risk factor value.
Choose only one for each of the five Risk Parameters.

WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factor Values					
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable	
	Risk Factor	1.0	(1.6)	3.2	4.5	
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30	
	Risk Factor	1.0	(1.2)	1.5	2.0	
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	(1.1)	1.2	1.4	1.6	1.6
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0	1.1	(1.2)	1.5	4.0*
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 Year		65 Years and Over or 1 Year and Younger		
	Risk Factor	1.0		(1.2)		

*A risk factor of 4.0 is charged to any zone that houses patients without any staff in immediate attendance.

Step 3 — Compute Occupancy Risk Factor (F) using Worksheet 4.7.3.
(1) Transfer the circled risk factor values from Worksheet 4.7.2 to the corresponding blocks in Worksheet 4.7.3.
(2) Compute F by multiplying the risk factor values as indicated in Worksheet 4.7.3.

WORKSHEET 4.7.3 - OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F	
OCCUPANCY RISK	1.6	X	1.2	X	1.1	X	1.2	X	1.2	=	3.0	(3)

Step 4 — Compute Adjusted Building Status (R) - Use Worksheets 4.7.4 or 4.7.5.
(1) If building is classified as "NEW" use Worksheet 4.7.4. If building is classified as "Existing" use Worksheet 4.7.5.
(2) Transfer the value of F from Worksheet 4.7.3 to Worksheets 4.7.4 or 4.7.5, as appropriate. Calculate R.
(3) Transfer R to the block labeled R in Worksheet 4.7.9.
(4) In Worksheets 4.7.4 and 4.7.5, results are always rounded up (i.e., 3.2 is rounded to 4.0).

WORKSHEET 4.7.4 ADJUSTED OCCUPANCY RISK FACTOR (NEW)

	F		R
1.0 X		=	

WORKSHEET 4.7.5 ADJUSTED OCCUPANCY RISK FACTOR (EXISTING)

	F		R	
0.6 X	3	=	1.8	(2)

Step 5 — Determine Safety Parameter Values using Worksheet 4.7.6.

(1) Select and circle the safety value for each safety parameter that best describes the conditions in the zone.
(2) Choose only one value for each of the 13 parameters.
(3) If two or more appear to apply, choose the one with the lowest point value.

WORKSHEET 4.7.6 – SAFETY PARAMETER VALUES

Safety Parameters	Parameters Values						
1. Construction	Combustible Types III, IV, and V				Non-Combustible Types I and II		
Floor or Zone	000	111	200	211, 2HH	000	111	222, 322, 442
First	(-2)	0	-2	0	0	2	2
Second	-7	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A				
	(-5(0))	0(3)[f]	3				
3. Interior Finish (Rooms)	Class C	Class B	Class A				
	(-3(1))	1(3)[f]	3				
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	>½ to <1 hour	≥1 hour			
	-10(0)[a]	0	1(0)[a]	(2(0))[a]			
5. Doors to Corridor	No Door	<20 min FPR	≥ 20 min FPR	≥ 20 min FPR and Auto Closure			
	-10	(0)	1(0)[d]	2(0)[d]			
6. Zone Dimensions	Dead End			No Dead Ends >30 ft. and Zone Length Is			
	>100 ft.	>50 ft. to 100 ft.	30 ft. to 50 ft.	>150 ft.	100 ft. to 150 ft.	<100 ft.	
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c] (0)[h]	0(0)[h]	(1)	
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resistance				
			<1 hr.	≥1 hr. to <2 hr.	≥2 hr.		
	-14	-10	0	(2(0))	3(0)[e]		
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies		
	In Zone	Outside Zone	In Zone	In Adjacent Zone			
	-11	-5	-6	(-2) **Laundry room**	0		
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mechanically Assisted Systems by Zone				
	-5(0)[c]	(0)	3				
10. Emergency Movement Routes	<2 Routes	Multiple Routes			Direct Exit(s)		
	-8	Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)			
		-2	0	(1)	5		
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm				
			W/O F.D. Conn.	W/F.D. Conn.			
	-4		1	(2)			
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces in Zone		
	0(3)[g]	2(3)[g]	3(3)[g]	(4)	5		
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building				
	0	8	(10)				

[a] Use (0) where parameter 5 is -10.

[b] Use (0) where parameter 10 is -8.

[c] Use (0) on floor with fewer than 31 patients (existing buildings only).

[d] Use (0) where parameter 4 is -10.

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200").
For SI Units: 1 ft.² = 0.3048 m²

[f] Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.

[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

[h] Use (0) where zone area ≤ 22,500 ft.² and distance from any point to reach a door in smoke barrier is ≤ 200 ft.

Step 6 — Compute Individual Safety Evaluations using Worksheet 4.7.7.

(1) Transfer each of the 13 circled Safety Parameter Values from Worksheet 4.7.6 to every unshaded block in the line with the corresponding Safety Parameter in Worksheet 4.7.7. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Worksheet 4.7.7 as 1/2 the corresponding value circled in Worksheet 4.7.6.

(2) Add the four columns, keeping in mind that any negative numbers deduct.

(3) Transfer the resulting total values for S1, S2, S3, S4 to blocks labeled S1, S2, S3, S4 in Worksheet 4.7.9 on page 4 of this sheet.

WORKSHEET 4.7.7 - INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-2	-2		-2
2. Interior Finish (Corr. and Exit)	-5		-5	-5
3. Interior Finish (Rooms)	-3			-3
4. Corridor Partitions and Walls	2			2
5. Doors to Corridor	0		0	0
6. Zone Dimensions			1	1
7. Vertical Openings	0		0	0
8. Hazardous Areas	-2	-2		-2
9. Smoke Control			0	0
10. Emergency Movement Routes			1	1
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		4	4	4
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 0	S_2= 12	S_3= 6	S_4= 8

Step 7 — Determine Mandatory Safety Requirement values using Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(1) Using the facility type (i.e., Hospital or Nursing Home), classification (i.e., New, Existing or Rehabilitated) and the floor where the zone is located, circle the appropriate value in each of the three columns found in Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(2) Transfer the three circled values to the blocks marked S_a, S_b, and S_c in Worksheet 4.7.9.

(3) The Mandatory Safety Requirement value for basements are based on the distance of the basement level from the closest level of discharge (See 4.6.1.2 and 4.6.1.3).

WORKSHEET 4.7.8A - MANDATORY SAFETY REQUIREMENTS – NEW HOSPITALS, EXISTING HOSPITALS OR NEW NURSING HOMES

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Existing	New	Existing	New	Existing
1st story	11	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher, but not high rise	18	9	19(16)[a]	6	11(8)[a]	3
High rise	18	17	19(16)[a]	16	11(8)[a]	7

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

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

WORKSHEET 4.7.8B - MANDATORY SAFETY REQUIREMENTS – EXISTING NURSING HOMES

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	(0)	(10)	(0)
2nd story	2	10	2
3rd story	6	14	2
4th story or higher	8	16	2

WORKSHEET 4.7.8C - MANDATORY SAFETY REQUIREMENTS – MAJOR REHABILITATION IN NONSPRINKLERED EXISTING HOSPITALS

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	13	17(14)*	8(5)*
2nd or 3rd story	17	19(16)*	10(7)*
4th story or higher	18	19(16)*	11(8)*

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

Step 8 — Identify Zone Fire Safety Equivalency using Worksheet 4.7.9.
(1) Transfer the three circled values from Worksheet 4.7.8A, 4.7.8B, or 4.7.8C to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.
(2) For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

WORKSHET 4.7.9 - ZONE FIRE SAFETY EQUIVALENCY EVALUATION

							YES	NO
Containment Safety (S_1)	minus	Mandatory Containment (Sa)	≥ 0	S_1 0	S_a 0	C = 0	X	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (Sb)	≥ 0	S_2 12	S_b 10	E = 2	X	
People Movement Safety (S_3)	minus	Mandatory People Movement (Sc)	≥0	S_3 6	S_c 0	P = 6	X	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 8	R 2	G = 6	X	

Step 9 — Evaluate other considerations not previously addressed using Worksheet 4.7.10.
Complete one copy of this separate worksheet for each facility.
For each consideration, select and mark the appropriate column.

WORKSHEET 4.7.10 FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	X		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			X
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	X		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	X		
E.	There are no flue-fed incinerators.	X		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	X		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	X		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.		X	
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.12 and 19.3.5.12.	X		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	X		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.1.	X		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			X

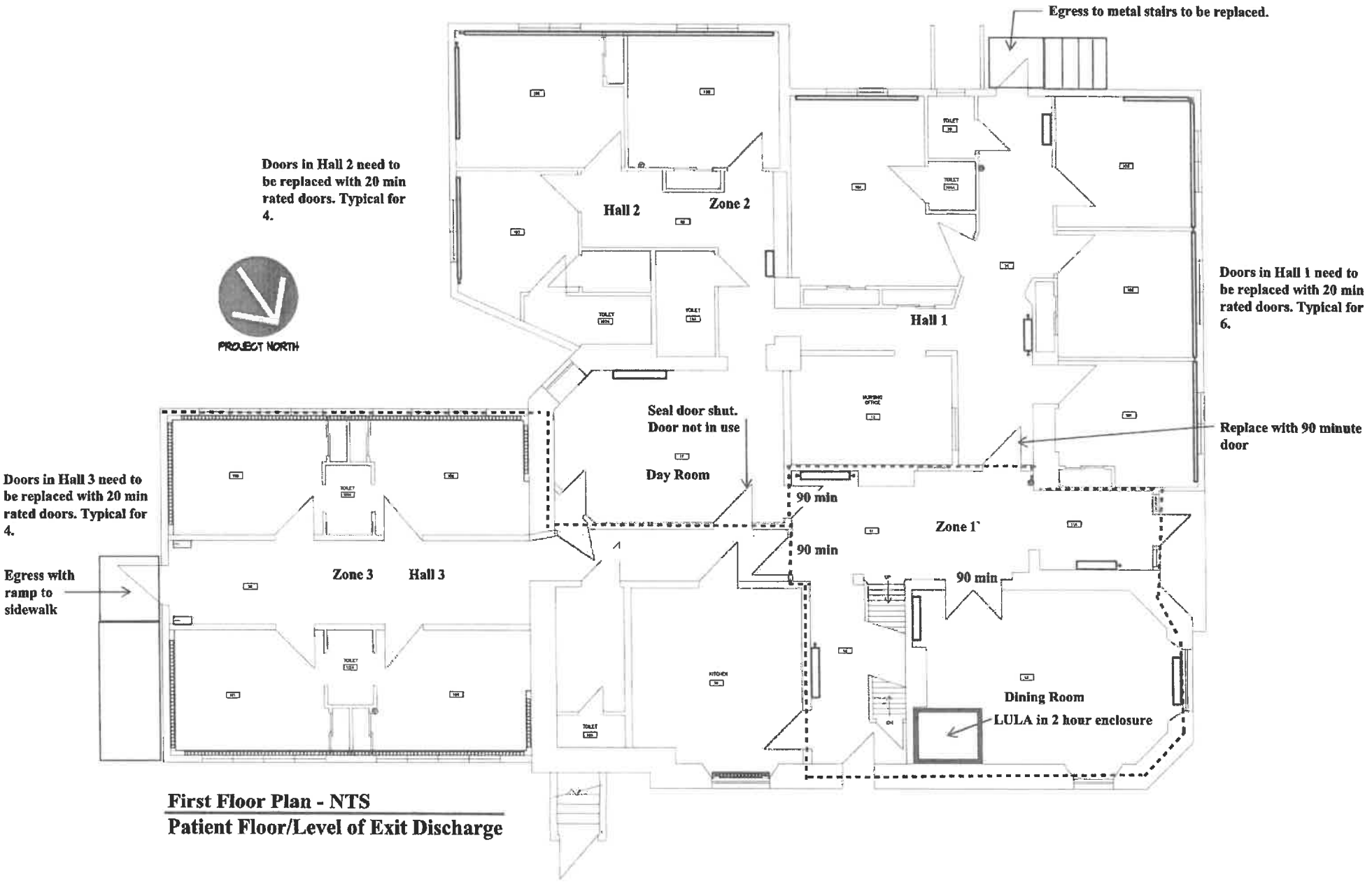
Step 10 — Determine the equivalency Conclusion to determine if the level of life safety is at least equivalent to that prescribed by the Life Safety Code using Worksheet 4.7.11.

WORKSHEET 4.7.11- CONCLUSIONS

1. ☐ All of the checks in Worksheet 4.7.9 are in the "Yes" column and all applicable considerations in Worksheet 4.7.10 are marked as "Met". The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

2. ☒ All of the checks in Worksheet 4.7.9 are in the "Yes" column and all considerations in Worksheet 4.7.10 marked as "Not Met" have been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

3. ☐ One or more of the checks on Worksheet 4.7.9 are in the "No" column or any considerations in Worksheet 4.7.10 marked as "Not Met" have NOT been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is not shown by this system to be equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.



First Floor Plan - NTS

Patient Floor/Level of Exit Discharge

FIRE SAFETY EVALUATION SYSTEM
HEALTH CARE FACILITIES

(NFPA 101A, "Guide on Alternative Approaches to Life Safety" 2013 Edition)

Complete the following worksheets for each fire/smoke zone*.
Where conditions are the same in several zones, one set of worksheets can be used for those zones.
* Fire/smoke zone is a space separated from all other spaces by floors, horizontal exits, or smoke barriers

Step 1 — Complete Cover Sheet using Worksheet 4.7.1.

WORKSHEET 4.7.1 – COVER SHEET

ZONE 3 OF 6 ZONES

First Floor, Zone 3, Hall 3, SE side

NAME OF FACILITY	ADDRESS OF FACILITY		
The Villa Rehab	**7 Forest Hill Dr., St. Albans, VT 05478**		
ZONE(S) EVALUATED **3 of 6 - First Floor**			
PROVIDER/VENDOR NO. **EHDanson Associates Architects**	DATE OF SURVEY **September 1, 27, 2022** Revised 11/28 to incorporate JH comments on 11/14.		
SURVEYOR SIGNATURE **Roy Ward** Roy Ward SURVEYOR ID	TITLE **Principal**	OFFICE	DATE
FIRE AUTHORITY SIGNATURE	TITLE	OFFICE	DATE

ADDITIONAL COMMENTS:

Recommended additional improvements for increased life safety (not required to meet FSES):
- Change corridor doors to 20 minute rated doors with lever hardware and smoke seals.
- Change corridor carpet to Class A rated material or confirm carpet meets that requirement.

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

Step 2 — Determine Occupancy Risk Parameter Factors using Worksheet 4.7.2.
For each Risk Parameter in Worksheet 7.2, select and circle the appropriate risk factor value.
Choose only one for each of the five Risk Parameters.

WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factor Values					
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable	
	Risk Factor	1.0	1.6	(3.2)	4.5	
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30	
	Risk Factor	1.0	(1.2)	1.5	2.0	
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	(1.1)	1.2	1.4	1.6	1.6
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0	1.1	(1.2)	1.5	4.0*
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 Year		65 Years and Over or 1 Year and Younger		
	Risk Factor	1.0		(1.2)		

*A risk factor of 4.0 is charged to any zone that houses patients without any staff in immediate attendance.

Step 3 — Compute Occupancy Risk Factor (F) using Worksheet 4.7.3.
(1) Transfer the circled risk factor values from Worksheet 4.7.2 to the corresponding blocks in Worksheet 4.7.3.
(2) Compute F by multiplying the risk factor values as indicated in Worksheet 4.7.3.

WORKSHEET 4.7.3 - OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F	
OCCUPANCY RISK	3.2	X	1.2	X	1.1	X	1.2	X	1.2	=	6.0	(6)

Step 4 — Compute Adjusted Building Status (R) - Use Worksheets 4.7.4 or 4.7.5.
(1) If building is classified as "NEW" use Worksheet 4.7.4. If building is classified as "Existing" use Worksheet 4.7.5.
(2) Transfer the value of F from Worksheet 4.7.3 to Worksheets 4.7.4 or 4.7.5, as appropriate. Calculate R.
(3) Transfer R to the block labeled R in Worksheet 4.7.9.
(4) In Worksheets 4.7.4 and 4.7.5, results are always rounded up (i.e., 3.2 is rounded to 4.0).

WORKSHEET 4.7.4 ADJUSTED OCCUPANCY RISK FACTOR (NEW)

	F		R
1.0 X		=	

WORKSHEET 4.7.5 ADJUSTED OCCUPANCY RISK FACTOR (EXISTING)

	F		R	
0.6 X	6	=	3.6	(4)

Step 5 — Determine Safety Parameter Values using Worksheet 4.7.6.

(1) Select and circle the safety value for each safety parameter that best describes the conditions in the zone.
(2) Choose only one value for each of the 13 parameters.
(3) If two or more appear to apply, choose the one with the lowest point value.

WORKSHEET 4.7.6 – SAFETY PARAMETER VALUES

Safety Parameters	Parameters Values						
1. Construction	Combustible Types III, IV, and V				Non-Combustible Types I and II		
Floor or Zone	000	111	200	211, 2HH	000	111	222, 322, 442
First	(-2)	0	-2	0	0	2	2
Second	-7	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A				
	(-5(0))	0(3)[f]	3				
3. Interior Finish (Rooms)	Class C	Class B	Class A				
	(-3(1))	1(3)[f]	3				
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	>½ to <1 hour	≥1 hour			
	-10(0)[a]	0	1(0)[a]	(2(0))			
5. Doors to Corridor	No Door	<20 min FPR	≥ 20 min FPR	≥ 20 min FPR and Auto Closure			
	-10	(0)	1(0)[d]	2(0)[d]			
6. Zone Dimensions	Dead End			No Dead Ends >30 ft. and Zone Length Is			
	>100 ft.	>50 ft. to 100 ft.	30 ft. to 50 ft.	>150 ft.	100 ft. to 150 ft.	<100 ft.	
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c] (0)[h]	0(0)[h]	(1)	
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resistance				
			<1 hr.	≥1 hr. to <2 hr.	≥2 hr.		
	-14	-10	0	(2(0))	3(0)[e]		
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies		
	In Zone	Outside Zone	In Zone	In Adjacent Zone			
	-11	-5	-6	(-2)	**Laundry Room** 0		
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mechanically Assisted Systems by Zone				
	-5(0)[c]	(0)	3				
10. Emergency Movement Routes	<2 Routes	Multiple Routes			Direct Exit(s)		
	-8	Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)			
		-2	0	(1)	5		
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm				
			W/O F.D. Conn.	W/F.D. Conn.			
	-4		1	(2)			
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces in Zone		
	0(3)[g]	2(3)[g]	3(3)[g]	(4)	5		
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building				
	0	8	(10)				

[a] Use (0) where parameter 5 is -10.

[b] Use (0) where parameter 10 is -8.

[c] Use (0) on floor with fewer than 31 patients (existing buildings only).

[d] Use (0) where parameter 4 is -10.

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200").
For SI Units: 1 ft.² = 0.3048 m²

[f] Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.

[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

[h] Use (0) where zone area ≤ 22,500 ft.² and distance from any point to reach a door in smoke barrier is ≤ 200 ft.

Step 6 — Compute Individual Safety Evaluations using Worksheet 4.7.7.

(1) Transfer each of the 13 circled Safety Parameter Values from Worksheet 4.7.6 to every unshaded block in the line with the corresponding Safety Parameter in Worksheet 4.7.7. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Worksheet 4.7.7 as 1/2 the corresponding value circled in Worksheet 4.7.6.

(2) Add the four columns, keeping in mind that any negative numbers deduct.

(3) Transfer the resulting total values for S1, S2, S3, S4 to blocks labeled S1, S2, S3, S4 in Worksheet 4.7.9 on page 4 of this sheet.

WORKSHEET 4.7.7 - INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-2	-2		-2
2. Interior Finish (Corr. and Exit)	-5		-5	-5
3. Interior Finish (Rooms)	-3			-3
4. Corridor Partitions and Walls	2			2
5. Doors to Corridor	0		0	0
6. Zone Dimensions			1	1
7. Vertical Openings	0		0	0
8. Hazardous Areas	-2	-2		-2
9. Smoke Control			0	0
10. Emergency Movement Routes			1	1
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		4	4	4
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 0	S_2= 12	S_3= 6	S_4= 8

Step 7 — Determine Mandatory Safety Requirement values using Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(1) Using the facility type (i.e., Hospital or Nursing Home), classification (i.e., New, Existing or Rehabilitated) and the floor where the zone is located, circle the appropriate value in each of the three columns found in Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(2) Transfer the three circled values to the blocks marked S_a, S_b, and S_c in Worksheet 4.7.9.

(3) The Mandatory Safety Requirement value for basements are based on the distance of the basement level from the closest level of discharge (See 4.6.1.2 and 4.6.1.3).

WORKSHEET 4.7.8A - MANDATORY SAFETY REQUIREMENTS – NEW HOSPITALS, EXISTING HOSPITALS OR NEW NURSING HOMES

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Existing	New	Existing	New	Existing
1st story	11	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher, but not high rise	18	9	19(16)[a]	6	11(8)[a]	3
High rise	18	17	19(16)[a]	16	11(8)[a]	7

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

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

WORKSHEET 4.7.8B - MANDATORY SAFETY REQUIREMENTS – EXISTING NURSING HOMES

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	(0)	(10)	(0)
2nd story	2	10	2
3rd story	6	14	2
4th story or higher	8	16	2

WORKSHEET 4.7.8C - MANDATORY SAFETY REQUIREMENTS – MAJOR REHABILITATION IN NONSPRINKLERED EXISTING HOSPITALS

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	13	17(14)*	8(5)*
2nd or 3rd story	17	19(16)*	10(7)*
4th story or higher	18	19(16)*	11(8)*

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

Step 8 — Identify Zone Fire Safety Equivalency using Worksheet 4.7.9.

(1) Transfer the three circled values from Worksheet 4.7.8A, 4.7.8B, or 4.7.8C to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.

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

WORKSHET 4.7.9 - ZONE FIRE SAFETY EQUIVALENCY EVALUATION

							YES	NO
Containment Safety (S_1)	minus	Mandatory Containment (Sa)	≥ 0	S_1 0	S_a 0	C = 0	X	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (Sb)	≥ 0	S_2 12	S_b 10	E = 2	X	
People Movement Safety (S_3)	minus	Mandatory People Movement (Sc)	≥0	S_3 6	S_c 0	P = 6	X	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 8	R 4	G = 2	X	

Step 9 — Evaluate other considerations not previously addressed using Worksheet 4.7.10.
Complete one copy of this separate worksheet for each facility.
For each consideration, select and mark the appropriate column.

WORKSHEET 4.7.10 FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	X		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			X
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	X		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	X		
E.	There are no flue-fed incinerators.	X		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	X		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	X		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.		X	
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.12 and 19.3.5.12.	X		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	X		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.1.	X		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			X

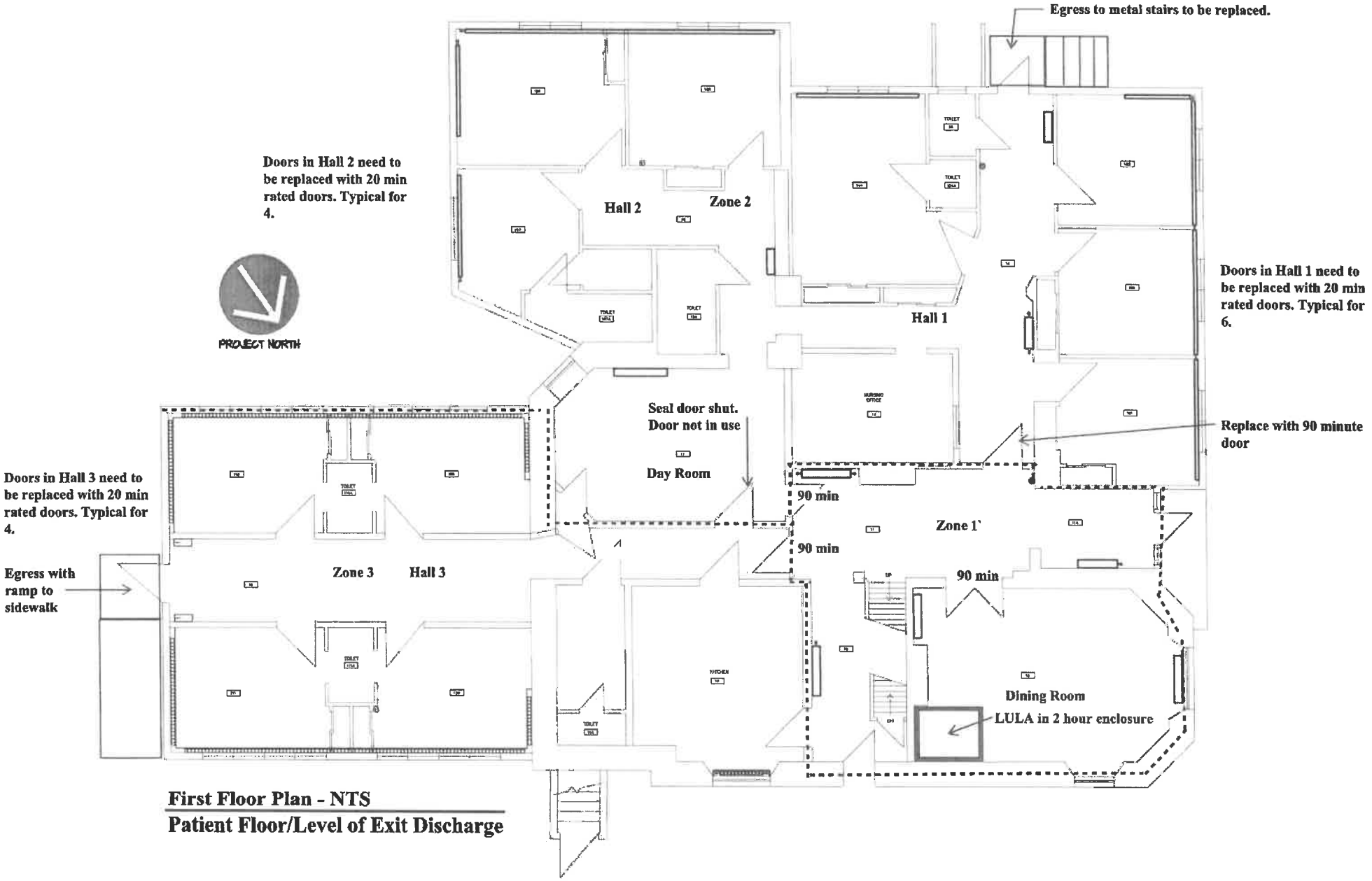
Step 10 — Determine the equivalency Conclusion to determine if the level of life safety is at least equivalent to that prescribed by the Life Safety Code using Worksheet 4.7.11.

WORKSHEET 4.7.11- CONCLUSIONS

1. ☐ All of the checks in Worksheet 4.7.9 are in the "Yes" column and all applicable considerations in Worksheet 4.7.10 are marked as "Met". The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

2. ☒ All of the checks in Worksheet 4.7.9 are in the "Yes" column and all considerations in Worksheet 4.7.10 marked as "Not Met" have been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

3. ☐ One or more of the checks on Worksheet 4.7.9 are in the "No" column or any considerations in Worksheet 4.7.10 marked as "Not Met" have NOT been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is not shown by this system to be equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.



First Floor Plan - NTS

Patient Floor/Level of Exit Discharge

FIRE SAFETY EVALUATION SYSTEM
HEALTH CARE FACILITIES

(NFPA 101A, "Guide on Alternative Approaches to Life Safety" 2013 Edition)

Complete the following worksheets for each fire/smoke zone*.
Where conditions are the same in several zones, one set of worksheets can be used for those zones.
* Fire/smoke zone is a space separated from all other spaces by floors, horizontal exits, or smoke barriers

Step 1 — Complete Cover Sheet using Worksheet 4.7.1.

WORKSHEET 4.7.1 – COVER SHEET

ZONE 4 OF 6 ZONES

Mitigation alternates included

Second Floor

NAME OF FACILITY	ADDRESS OF FACILITY		
The Villa Rehab			
ZONE(S) EVALUATED			
Zone 4 - Second Floor			
PROVIDER/VENDOR NO.	DATE OF SURVEY		
EHDanson Associates Architects	**September 1, 27, 2022** Revised 11/28 to incorporate JH comments on 11/14.		
SURVEYOR SIGNATURE	TITLE	OFFICE	DATE
Roy Ward Roy Ward	**Principal**		
SURVEYOR ID			
FIRE AUTHORITY SIGNATURE	TITLE	OFFICE	DATE

ADDITIONAL COMMENTS:

Recommended mitigation for compliance:
- **Remove and replace carpet and wall coverings in main stair. Replace with Class A finish.**
- **Remove and replace carpet in rear egress and in corridor. Replace with Class A finish.**
- **Add 20 minute door where shown.**
- **Increase smoke detector and alarm in all spaces**

Implementation of mitigation measures in existing construction must be carefully reviewed prior to developing a specific plan.

Mitigation measures complete compliance for S_1, S_2, S_3, and S_4.

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

Step 2 — Determine Occupancy Risk Parameter Factors using Worksheet 4.7.2.
For each Risk Parameter in Worksheet 7.2, select and circle the appropriate risk factor value.
Choose only one for each of the five Risk Parameters.

WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factor Values					
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable	
	Risk Factor	1.0	1.6	(3.2)	4.5	
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30	
	Risk Factor	1.0	(1.2)	1.5	2.0	
3. Zone Location *(L)*	Floor	1st	(2nd or 3rd)	4th to 6th	7th and Above	Basements
	Risk Factor	1.1	(1.2)	1.4	1.6	1.6
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0	1.1	(1.2)	1.5	4.0*
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 Year		65 Years and Over or 1 Year and Younger		
	Risk Factor	1.0		(1.2)		

*A risk factor of 4.0 is charged to any zone that houses patients without any staff in immediate attendance.

Step 3 — Compute Occupancy Risk Factor (F) using Worksheet 4.7.3.
(1) Transfer the circled risk factor values from Worksheet 4.7.2 to the corresponding blocks in Worksheet 4.7.3.
(2) Compute F by multiplying the risk factor values as indicated in Worksheet 4.7.3.

WORKSHEET 4.7.3 - OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	1.2	X	1.2	X	1.2	X	1.2	=	6.7

Step 4 — Compute Adjusted Building Status (R) - Use Worksheets 4.7.4 or 4.7.5.
(1) If building is classified as "NEW" use Worksheet 4.7.4. If building is classified as "Existing" use Worksheet 4.7.5.
(2) Transfer the value of F from Worksheet 4.7.3 to Worksheets 4.7.4 or 4.7.5, as appropriate. Calculate R.
(3) Transfer R to the block labeled R in Worksheet 4.7.9.
(4) In Worksheets 4.7.4 and 4.7.5, results are always rounded up (i.e., 3.2 is rounded to 4.0).

WORKSHEET 4.7.4 ADJUSTED OCCUPANCY RISK FACTOR (NEW)

	F		R
1.0 X		=	

WORKSHEET 4.7.5 ADJUSTED OCCUPANCY RISK FACTOR (EXISTING)

	F		R
0.6 X	6.7	=	4.0

Step 5 — Determine Safety Parameter Values using Worksheet 4.7.6.

(1) Select and circle the safety value for each safety parameter that best describes the conditions in the zone.
(2) Choose only one value for each of the 13 parameters.
(3) If two or more appear to apply, choose the one with the lowest point value.

WORKSHEET 4.7.6 – SAFETY PARAMETER VALUES

Safety Parameters	Parameters Values						
1. Construction	Combustible Types III, IV, and V				Non-Combustible Types I and II		
Floor or Zone	000	111	200	211, 2HH	000	111	222, 322, 442
First	-2	0	-2	0	0	2	2
Second	(-7)	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4

2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A			
	-5(0)[f]	0(3)[f]	(3)			
3. Interior Finish (Rooms)	Class C	Class B	Class A			
	(-3(1))	1(3)[f]	3			
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	>½ to <1 hour	≥1 hour		
	-10(0)[e]	0	1(0)[e]	(2(0)[e])		
5. Doors to Corridor	No Door	<20 min FPR	≥ 20 min FPR	≥ 20 min FPR and Auto Closure		
	-10	0	1(0)[d]	(2(0)[d])		

6. Zone Dimensions	Dead End			No Dead Ends >30 ft. and Zone Length Is		
	>100 ft.	>50 ft. to 100 ft.	30 ft. to 50 ft.	>150 ft.	100 ft. to 150 ft.	<100 ft.
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c] (0)[h]	0(0)[h]	(1)

7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resistance		
			<1 hr.	≥1 hr. to <2 hr.	≥2 hr.
	-14	-10	0	(2(0)[e])	3(0)[e]

8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies
	In Zone	Outside Zone	In Zone	In Adjacent Zone	
	-11	-5	-6	-2	(0)

9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mechanically Assisted Systems by Zone	
	(-5(0))	0	3	

10. Emergency Movement Routes	<2 Routes	Multiple Routes			Direct Exit(s)
	-8	Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	
		-2	(0)	1	5

11. Manual Fire Alarm	No Manual Fire Alarm	Manual Fire Alarm	
		W/O F.D. Conn.	W/F.D. Conn.
	-4	1	(2)

12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces in Zone
	0(3)[g]	2(3)[g]	3(3)[g]	4	(5)

13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building	
	0	8	(10)	

[a] Use (0) where parameter 5 is -10.

[b] Use (0) where parameter 10 is -8.

[c] Use (0) on floor with fewer than 31 patients (existing buildings only).

[d] Use (0) where parameter 4 is -10.

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200").
For SI Units: 1 ft.² = 0.3048 m²

[f] Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.

[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

[h] Use (0) where zone area ≤ 22,500 ft.² and distance from any point to reach a door in smoke barrier is ≤ 200 ft.

Step 6 — Compute Individual Safety Evaluations using Worksheet 4.7.7.

(1) Transfer each of the 13 circled Safety Parameter Values from Worksheet 4.7.6 to every unshaded block in the line with the corresponding Safety Parameter in Worksheet 4.7.7. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Worksheet 4.7.7 as 1/2 the corresponding value circled in Worksheet 4.7.6.

(2) Add the four columns, keeping in mind that any negative numbers deduct.

(3) Transfer the resulting total values for S1, S2, S3, S4 to blocks labeled S1, S2, S3, S4 in Worksheet 4.7.9 on page 4 of this sheet.

WORKSHEET 4.7.7 - INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-7	-7		-7
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	-3			-3
4. Corridor Partitions and Walls	2			2
5. Doors to Corridor	2		2	2
6. Zone Dimensions			1	1
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		5	5	5
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 7	S_2= 10	S_3= 16	S_4= 15

Step 7 — Determine Mandatory Safety Requirement values using Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(1) Using the facility type (i.e., Hospital or Nursing Home), classification (i.e., New, Existing or Rehabilitated) and the floor where the zone is located, circle the appropriate value in each of the three columns found in Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(2) Transfer the three circled values to the blocks marked S_a, S_b, and S_c in Worksheet 4.7.9.

(3) The Mandatory Safety Requirement value for basements are based on the distance of the basement level from the closest level of discharge (See 4.6.1.2 and 4.6.1.3).

WORKSHEET 4.7.8A - MANDATORY SAFETY REQUIREMENTS – NEW HOSPITALS, EXISTING HOSPITALS OR NEW NURSING HOMES

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Existing	New	Existing	New	Existing
1st story	11	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher, but not high rise	18	9	19(16)[a]	6	11(8)[a]	3
High rise	18	17	19(16)[a]	16	11(8)[a]	7

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

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

WORKSHEET 4.7.8B - MANDATORY SAFETY REQUIREMENTS – EXISTING NURSING HOMES

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	0	10	0
2nd story	(2)	(10)	(2)
3rd story	6	14	2
4th story or higher	8	16	2

WORKSHEET 4.7.8C - MANDATORY SAFETY REQUIREMENTS – MAJOR REHABILITATION IN NONSPRINKLERED EXISTING HOSPITALS

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	13	17(14)*	8(5)*
2nd or 3rd story	17	19(16)*	10(7)*
4th story or higher	18	19(16)*	11(8)*

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

Step 8 — Identify Zone Fire Safety Equivalency using Worksheet 4.7.9.
(1) Transfer the three circled values from Worksheet 4.7.8A, 4.7.8B, or 4.7.8C to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.
(2) For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

WORKSHEET 4.7.9 - ZONE FIRE SAFETY EQUIVALENCY EVALUATION

							YES	NO
Containment Safety (S_1)	minus	Mandatory Containment (Sa)	≥ 0	S_1 7	S_a 2	C = 5	X	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (Sb)	≥ 0	S_2 10	S_b 10	E = 0	X	
People Movement Safety (S_3)	minus	Mandatory People Movement (Sc)	≥0	S_3 16	S_c 2	P = 14	X	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 15	R 4	G = 11	X	

Step 9 — Evaluate other considerations not previously addressed using Worksheet 4.7.10.
Complete one copy of this separate worksheet for each facility.
For each consideration, select and mark the appropriate column.

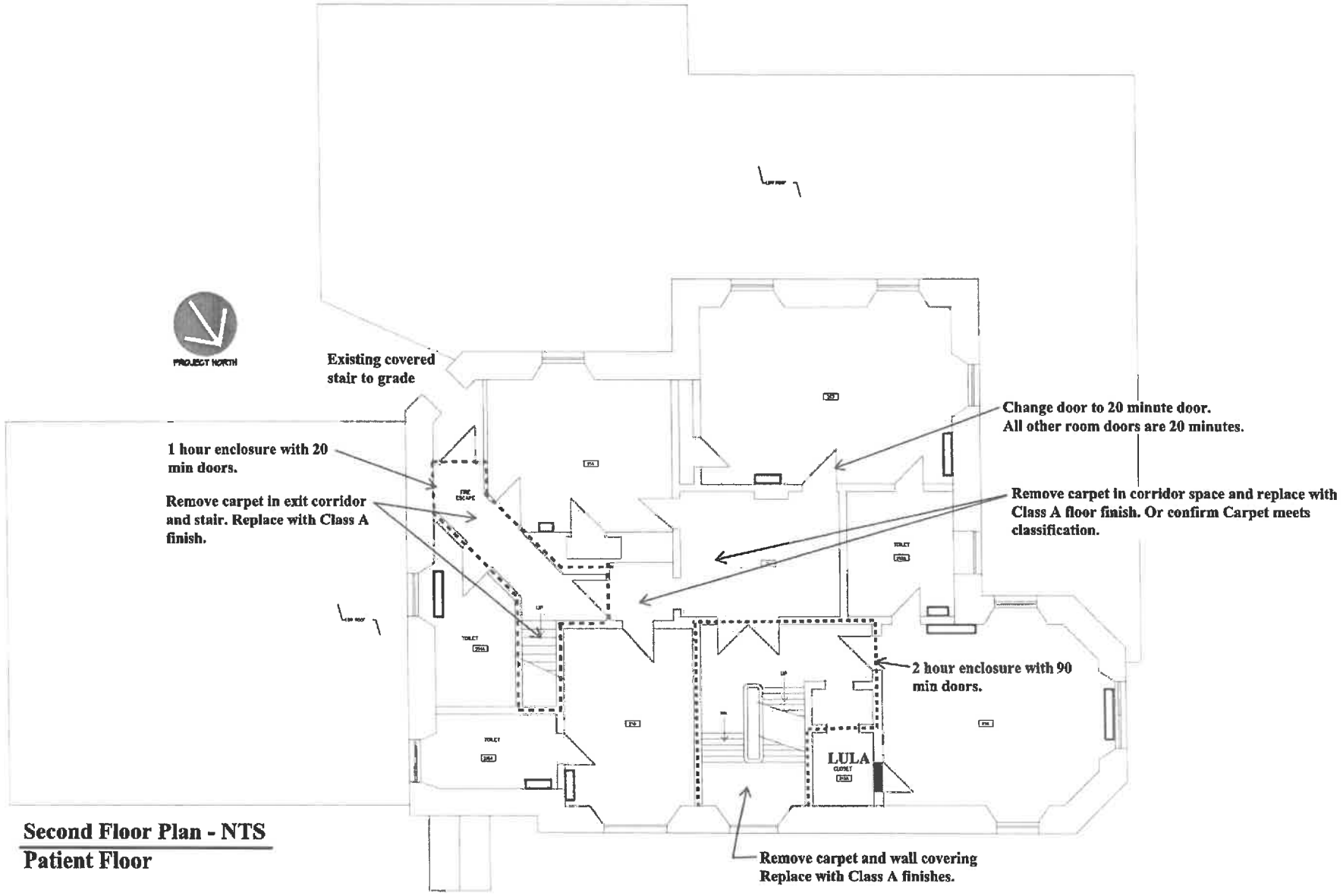
WORKSHEET 4.7.10 FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	X		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			X
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	X		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	X		
E.	There are no flue-fed incinerators.	X		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	X		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	X		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.		X	
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.12 and 19.3.5.12.	X		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	X		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.1.	X		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			X

Step 10 — Determine the equivalency Conclusion to determine if the level of life safety is at least equivalent to that prescribed by the Life Safety Code using Worksheet 4.7.11.

WORKSHEET 4.7.11- CONCLUSIONS

1.	[X]	All of the checks in Worksheet 4.7.9 are in the "Yes" column and all applicable considerations in Worksheet 4.7.10 are marked as "Met". The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.
2.	[ ]	All of the checks in Worksheet 4.7.9 are in the "Yes" column and all considerations in Worksheet 4.7.10 marked as "Not Met" have been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.
3.	[ ]	One or more of the checks on Worksheet 4.7.9 are in the "No" column or any considerations in Worksheet 4.7.10 marked as "Not Met" have NOT been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is not shown by this system to be equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.



Second Floor Plan - NTS
Patient Floor

FIRE SAFETY EVALUATION SYSTEM
HEALTH CARE FACILITIES

(NFPA 101A, "Guide on Alternative Approaches to Life Safety" 2013 Edition)

Complete the following worksheets for each fire/smoke zone*.
Where conditions are the same in several zones, one set of worksheets can be used for those zones.
* Fire/smoke zone is a space separated from all other spaces by floors, horizontal exits, or smoke barriers

Step 1 — Complete Cover Sheet using Worksheet 4.7.1.

WORKSHEET 4.7.1 – COVER SHEET

ZONE 5 OF 6 ZONES

Mitigation alternates included

Third Floor

NAME OF FACILITY	ADDRESS OF FACILITY		
The Villa Rehab			
ZONE(S) EVALUATED **Zone 5 - Third Floor**			
PROVIDER/VENDOR NO.	DATE OF SURVEY **September 1, 27, 2022** Revised 11/28 to incorporate JH comments on 11/14.		
SURVEYOR SIGNATURE **Roy Ward** Roy Ward	TITLE **Principal**	OFFICE	DATE
SURVEYOR ID			
FIRE AUTHORITY SIGNATURE	TITLE	OFFICE	DATE

ADDITIONAL COMMENTS:

The third floor is administrative space only and has no patients.

Mitigation measures for compliance:
- **Add drywall to interior of storage room to cover all wood. Create 1 hour enclosure at storage room wall. Replace existing door to storage to 20 minute door.**
- **Install 20 minute doors to corridor rooms except for stair door to remain.**
- **Remove carpet and wall covering in stairs and replace with Class A finish.**
- **Add smoke detector in office**

Implementation of mitigation measures in existing construction must be carefully reviewed prior to developing a specific plan.

Mitigation noted above will resolve S_1, S_3 and S_4 but will not resolve S_2.

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

Step 2 — Determine Occupancy Risk Parameter Factors using Worksheet 4.7.2.
For each Risk Parameter in Worksheet 7.2, select and circle the appropriate risk factor value.
Choose only one for each of the five Risk Parameters.

WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factor Values					
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable	
	Risk Factor	(1.0)	1.6	3.2	4.5	
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30	
	Risk Factor	(1.0)	1.2	1.5	2.0	
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	1.1	(1.2)	1.4	1.6	1.6
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	(1.0)	1.1	1.2	1.5	4.0*
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 Year		65 Years and Over or 1 Year and Younger		
	Risk Factor	(1.0)		1.2		

*A risk factor of 4.0 is charged to any zone that houses patients without any staff in immediate attendance.

Step 3 — Compute Occupancy Risk Factor (F) using Worksheet 4.7.3.
(1) Transfer the circled risk factor values from Worksheet 4.7.2 to the corresponding blocks in Worksheet 4.7.3.
(2) Compute F by multiplying the risk factor values as indicated in Worksheet 4.7.3.

WORKSHEET 4.7.3 - OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	1	X	1	X	1.2	X	1	X	1	=	1.2

Step 4 — Compute Adjusted Building Status (R) - Use Worksheets 4.7.4 or 4.7.5.
(1) If building is classified as "NEW" use Worksheet 4.7.4. If building is classified as "Existing" use Worksheet 4.7.5.
(2) Transfer the value of F from Worksheet 4.7.3 to Worksheets 4.7.4 or 4.7.5, as appropriate. Calculate R.
(3) Transfer R to the block labeled R in Worksheet 4.7.9.
(4) In Worksheets 4.7.4 and 4.7.5, results are always rounded up (i.e., 3.2 is rounded to 4.0).

WORKSHEET 4.7.4 ADJUSTED OCCUPANCY RISK FACTOR (NEW)

	F		R
1.0 X		=	

WORKSHEET 4.7.5 ADJUSTED OCCUPANCY RISK FACTOR (EXISTING)

	F		R
0.6 X	1.2	=	1.0

Step 5 — Determine Safety Parameter Values using Worksheet 4.7.6.

(1) Select and circle the safety value for each safety parameter that best describes the conditions in the zone.
(2) Choose only one value for each of the 13 parameters.
(3) If two or more appear to apply, choose the one with the lowest point value.

WORKSHEET 4.7.6 – SAFETY PARAMETER VALUES

Safety Parameters	Parameters Values						
1. Construction	Combustible Types III, IV, and V				Non-Combustible Types I and II		
Floor or Zone	000	111	200	211, 2HH	000	111	222, 322, 442
First	-2	0	-2	0	0	2	2
Second	-7	-2	-4	-2	-2	2	4
Third	(-9)	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A				
	-5(0)[f]	0(3)[f]	(3)				
3. Interior Finish (Rooms)	Class C	Class B	Class A				
	-3(1)[f]	1(3)[f]	(3)				
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	>½ to <1 hour	≥1 hour			
	-10(0)[a]	0	(1(0))[a]	2(0)[e]			
5. Doors to Corridor	No Door	<20 min FPR	≥ 20 min FPR	≥ 20 min FPR and Auto Closure			
	-10	0	1(0)[d]	(2(0))			
6. Zone Dimensions	Dead End			No Dead Ends >30 ft. and Zone Length Is			
	>100 ft.	>50 ft. to 100 ft.	30 ft. to 50 ft.	>150 ft.	100 ft. to 150 ft.	<100 ft.	
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c] (0)[h]	0(0)[h]	(1)	
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resistance				
			<1 hr.	≥1 hr. to <2 hr.	≥2 hr.		
	-14	-10	0	(2(0))	3(0)[e]		
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies		
	In Zone	Outside Zone	In Zone	In Adjacent Zone			
	-11	-5	-6	-2	(0)		
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mechanically Assisted Systems by Zone				
	(-5(0))[e]	0	3				
10. Emergency Movement Routes	<2 Routes	Multiple Routes			Direct Exit(s)		
	-8	Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)			
		-2	(0)	1	5		
11. Manual Fire Alarm	No Manual Fire Alarm	Manual Fire Alarm					
		W/O F.D. Conn.	W/F.D. Conn.				
	-4	1	(2)				
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces in Zone		
	0(3)[g]	2(3)[g]	3(3)[g]	(4)	5		
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building				
	0	8	(10)				

[a] Use (0) where parameter 5 is -10.

[b] Use (0) where parameter 10 is -8.

[c] Use (0) on floor with fewer than 31 patients (existing buildings only).

[d] Use (0) where parameter 4 is -10.

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200").
For SI Units: 1 ft.² = 0.3048 m²

[f] Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.

[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

[h] Use (0) where zone area ≤ 22,500 ft.² and distance from any point to reach a door in smoke barrier is ≤ 200 ft.

Step 6 — Compute Individual Safety Evaluations using Worksheet 4.7.7.

(1) Transfer each of the 13 circled Safety Parameter Values from Worksheet 4.7.6 to every unshaded block in the line with the corresponding Safety Parameter in Worksheet 4.7.7. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Worksheet 4.7.7 as 1/2 the corresponding value circled in Worksheet 4.7.6.

(2) Add the four columns, keeping in mind that any negative numbers deduct.

(3) Transfer the resulting total values for S1, S2, S3, S4 to blocks labeled S1, S2, S3, S4 in Worksheet 4.7.9 on page 4 of this sheet.

WORKSHEET 4.7.7 - INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-9	-9		-9
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions and Walls	1			1
5. Doors to Corridor	2		2	2
6. Zone Dimensions			1	1
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		4	4	4
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 10	S_2= 7	S_3= 15	S_4= 17

Step 7 — Determine Mandatory Safety Requirement values using Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(1) Using the facility type (i.e., Hospital or Nursing Home), classification (i.e., New, Existing or Rehabilitated) and the floor where the zone is located, circle the appropriate value in each of the three columns found in Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(2) Transfer the three circled values to the blocks marked S_a, S_b, and S_c in Worksheet 4.7.9.

(3) The Mandatory Safety Requirement value for basements are based on the distance of the basement level from the closest level of discharge (See 4.6.1.2 and 4.6.1.3).

WORKSHEET 4.7.8A - MANDATORY SAFETY REQUIREMENTS – NEW HOSPITALS, EXISTING HOSPITALS OR NEW NURSING HOMES

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Existing	New	Existing	New	Existing
1st story	11	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher, but not high rise	18	9	19(16)[a]	6	11(8)[a]	3
High rise	18	17	19(16)[a]	16	11(8)[a]	7

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

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

WORKSHEET 4.7.8B - MANDATORY SAFETY REQUIREMENTS – EXISTING NURSING HOMES

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	0	10	0
2nd story	2	10	2
3rd story	(6)	(14)	(2)
4th story or higher	8	16	2

WORKSHEET 4.7.8C - MANDATORY SAFETY REQUIREMENTS – MAJOR REHABILITATION IN NONSPRINKLERED EXISTING HOSPITALS

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	13	17(14)*	8(5)*
2nd or 3rd story	17	19(16)*	10(7)*
4th story or higher	18	19(16)*	11(8)*

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

Step 8 — Identify Zone Fire Safety Equivalency using Worksheet 4.7.9.

(1) Transfer the three circled values from Worksheet 4.7.8A, 4.7.8B, or 4.7.8C to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.

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

WORKSHET 4.7.9 - ZONE FIRE SAFETY EQUIVALENCY EVALUATION

							YES	NO
Containment Safety (S_1)	minus	Mandatory Containment (Sa)	≥ 0	S_1 10	S_a 6	C = 4	X	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (Sb)	≥ 0	S_2 7	S_b 14	E = -7		X
People Movement Safety (S_3)	minus	Mandatory People Movement (Sc)	≥0	S_3 15	S_c 2	P = 13	X	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 17	R 1	G = 16	X	

Step 9 — Evaluate other considerations not previously addressed using Worksheet 4.7.10.
Complete one copy of this separate worksheet for each facility.
For each consideration, select and mark the appropriate column.

WORKSHEET 4.7.10 FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	X		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			X
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	X		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	X		
E.	There are no flue-fed incinerators.	X		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	X		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	X		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.		X	
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.12 and 19.3.5.12.	X		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	X		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.1.	X		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			X

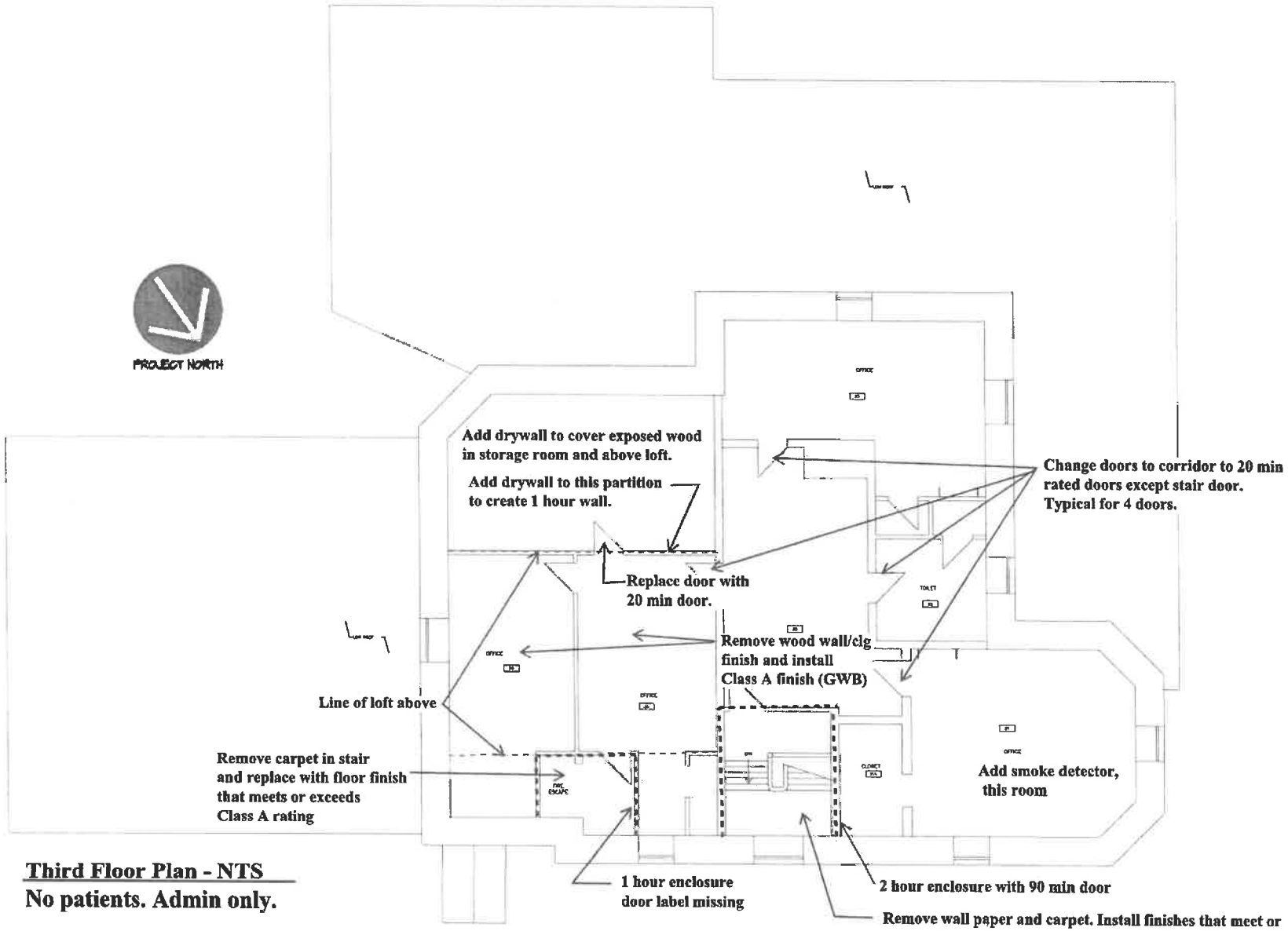
Step 10 — Determine the equivalency Conclusion to determine if the level of life safety is at least equivalent to that prescribed by the Life Safety Code using Worksheet 4.7.11.

WORKSHEET 4.7.11- CONCLUSIONS

1. ☐ All of the checks in Worksheet 4.7.9 are in the "Yes" column and all applicable considerations in Worksheet 4.7.10 are marked as "Met". The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

2. ☐ All of the checks in Worksheet 4.7.9 are in the "Yes" column and all considerations in Worksheet 4.7.10 marked as "Not Met" have been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

3. ☒ One or more of the checks on Worksheet 4.7.9 are in the "No" column or any considerations in Worksheet 4.7.10 marked as "Not Met" have NOT been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is not shown by this system to be equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.



Third Floor Plan - NTS

No patients. Admin only.

FIRE SAFETY EVALUATION SYSTEM
HEALTH CARE FACILITIES

(NFPA 101A, "Guide on Alternative Approaches to Life Safety" 2013 Edition)

Complete the following worksheets for each fire/smoke zone*.
Where conditions are the same in several zones, one set of worksheets can be used for those zones.
* Fire/smoke zone is a space separated from all other spaces by floors, horizontal exits, or smoke barriers

Step 1 — Complete Cover Sheet using Worksheet 4.7.1.

WORKSHEET 4.7.1 – COVER SHEET

Mitigation alternates included

ZONE 6 OF 6 ZONES
Basement

NAME OF FACILITY	ADDRESS OF FACILITY		
The Villa Rehab			
ZONE(S) EVALUATED			
6 of 6 Basement			
PROVIDER/VENDOR NO.	DATE OF SURVEY		
EHDanson Associate Architects	**September 1, 27, 2022** Revised 11/28 to incorporate JH comments on 11/14.		
SURVEYOR SIGNATURE	TITLE	OFFICE	DATE
Roy Ward Roy Ward	**Principal**		
SURVEYOR ID			
FIRE AUTHORITY SIGNATURE	TITLE	OFFICE	DATE

ADDITIONAL COMMENTS:
Recommended mitigation for compliance:

- **Basement requires doors to isolate corridor egress path.**
- **Laundry is >100sf and is classified as hazardous area. This space should be isolated from egress with rated doors and ceiling.**
- **In general the ceiling is wood except in boiler room. Ceiling should be non-combustible material.**
- **Wood walls and framing should be enclosed in gypsum wall board.**
- **Add smoke detection in all spaces.**

Note that adding non-combustible material (drywall or equivalent) to ceiling requires removal and replacement of piping, wiring and conduits attached to ceiling.

Further evaluation of recommended mitigation measures is required to determine actual scope of work required.

Mitigation measures complete compliance for S_1, S_2, S_3 and S_4.

Step 2 — Determine Occupancy Risk Parameter Factors using Worksheet 4.7.2.
For each Risk Parameter in Worksheet 7.2, select and circle the appropriate risk factor value.
Choose only one for each of the five Risk Parameters.

WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factor Values					
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable	
	Risk Factor	(1.0)	1.6	3.2	4.5	
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30	
	Risk Factor	(1.0)	1.2	1.5	2.0	
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	1.1	1.2	1.4	1.6	(1.6)
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	(1.0)	1.1	1.2	1.5	4.0*
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 Year		65 Years and Over or 1 Year and Younger		
	Risk Factor	(1.0)		1.2		

*A risk factor of 4.0 is charged to any zone that houses patients without any staff in immediate attendance.

Step 3 — Compute Occupancy Risk Factor (F) using Worksheet 4.7.3.
(1) Transfer the circled risk factor values from Worksheet 4.7.2 to the corresponding blocks in Worksheet 4.7.3.
(2) Compute F by multiplying the risk factor values as indicated in Worksheet 4.7.3.

WORKSHEET 4.7.3 - OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	1.0	X	1.0	X	1.6	X	1.0	X	1.0	=	1.6

Step 4 — Compute Adjusted Building Status (R) - Use Worksheets 4.7.4 or 4.7.5.
(1) If building is classified as "NEW" use Worksheet 4.7.4. If building is classified as "Existing" use Worksheet 4.7.5.
(2) Transfer the value of F from Worksheet 4.7.3 to Worksheets 4.7.4 or 4.7.5, as appropriate. Calculate R.
(3) Transfer R to the block labeled R in Worksheet 4.7.9.
(4) In Worksheets 4.7.4 and 4.7.5, results are always rounded up (i.e., 3.2 is rounded to 4.0).

WORKSHEET 4.7.4 ADJUSTED OCCUPANCY RISK FACTOR (NEW)

	F		R
1.0 X		=	

WORKSHEET 4.7.5 ADJUSTED OCCUPANCY RISK FACTOR (EXISTING)

	F		R	
0.6 X	1.6	=	.96	(1)

Step 5 — Determine Safety Parameter Values using Worksheet 4.7.6.

(1) Select and circle the safety value for each safety parameter that best describes the conditions in the zone.
(2) Choose only one value for each of the 13 parameters.
(3) If two or more appear to apply, choose the one with the lowest point value.

WORKSHEET 4.7.6 – SAFETY PARAMETER VALUES

Safety Parameters	Parameters Values						
1. Construction	Combustible Types III, IV, and V				Non-Combustible Types I and II		
Floor or Zone	000	111	200	211, 2HH	000	111	222, 322, 442
First	-2	0	-2	0	0	2	2
Second	(-7)	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A				
	-5(0)[f]	0(3)[f]	(3)				
3. Interior Finish (Rooms)	Class C	Class B	Class A				
	-3(1)[f]	1(3)[f]	(3)				
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	>½ to <1 hour	≥1 hour			
	-10(0)[a]	0	1(0)[a]	(2(0)[a])			
5. Doors to Corridor	No Door	<20 min FPR	≥ 20 min FPR	≥ 20 min FPR and Auto Closure			
	-10	0	1(0)[d]	(2(0)[d])			
6. Zone Dimensions	Dead End			No Dead Ends >30 ft. and Zone Length Is			
	>100 ft.	>50 ft. to 100 ft.	30 ft. to 50 ft.	>150 ft.	100 ft. to 150 ft.	<100 ft.	
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c] (0)[h]	0(0)[h]	(1)	
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resistance				
			<1 hr.	≥1 hr. to <2 hr.	≥2 hr.		
	-14	-10	0	(2(0)[e])	3(0)[e]		
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies		
	In Zone	Outside Zone	In Zone	In Adjacent Zone			
	-11	-5	-6	-2	(0)		
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mechanically Assisted Systems by Zone				
	(-5(0)[c])	0	3				
10. Emergency Movement Routes	<2 Routes	Multiple Routes			Direct Exit(s)		
	-8	Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)			
		-2	(0)	1	5		
11. Manual Fire Alarm	No Manual Fire Alarm	Manual Fire Alarm					
		W/O F.D. Conn.	W/F.D. Conn.				
	-4	1	(2)				
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces in Zone		
	0(3)[g]	2(3)[g]	3(3)[g]	4	(5)		
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building				
	0	8	(10)				

[a] Use (0) where parameter 5 is -10.

[b] Use (0) where parameter 10 is -8.

[c] Use (0) on floor with fewer than 31 patients (existing buildings only).

[d] Use (0) where parameter 4 is -10.

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200").
For SI Units: 1 ft.² = 0.3048 m²

[f] Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.

[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

[h] Use (0) where zone area ≤ 22,500 ft.² and distance from any point to reach a door in smoke barrier is ≤ 200 ft.

Step 6 — Compute Individual Safety Evaluations using Worksheet 4.7.7.

(1) Transfer each of the 13 circled Safety Parameter Values from Worksheet 4.7.6 to every unshaded block in the line with the corresponding Safety Parameter in Worksheet 4.7.7. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Worksheet 4.7.7 as 1/2 the corresponding value circled in Worksheet 4.7.6.

(2) Add the four columns, keeping in mind that any negative numbers deduct.

(3) Transfer the resulting total values for S1, S2, S3, S4 to blocks labeled S1, S2, S3, S4 in Worksheet 4.7.9 on page 4 of this sheet.

WORKSHEET 4.7.7 - INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-7	-7		-7
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions and Walls	2			2
5. Doors to Corridor	2		2	2
6. Zone Dimensions			1	1
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		5	5	5
13. Automatic Sprinklers	10	10	10 · 2 = 5	10
Total Value	S_1= 13	S_2= 10	S_3= 16	S_4= 21

Step 7 — Determine Mandatory Safety Requirement values using Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(1) Using the facility type (i.e., Hospital or Nursing Home), classification (i.e., New, Existing or Rehabilitated) and the floor where the zone is located, circle the appropriate value in each of the three columns found in Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(2) Transfer the three circled values to the blocks marked S_a, S_b, and S_c in Worksheet 4.7.9.

(3) The Mandatory Safety Requirement value for basements are based on the distance of the basement level from the closest level of discharge (See 4.6.1.2 and 4.6.1.3).

WORKSHEET 4.7.8A - MANDATORY SAFETY REQUIREMENTS – NEW HOSPITALS, EXISTING HOSPITALS OR NEW NURSING HOMES

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Existing	New	Existing	New	Existing
1st story	11	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher, but not high rise	18	9	19(16)[a]	6	11(8)[a]	3
High rise	18	17	19(16)[a]	16	11(8)[a]	7

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

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

WORKSHEET 4.7.8B - MANDATORY SAFETY REQUIREMENTS – EXISTING NURSING HOMES

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	0	10	0
2nd story	(2)	(10)	(2)
3rd story	6	14	2
4th story or higher	8	16	2

WORKSHEET 4.7.8C - MANDATORY SAFETY REQUIREMENTS – MAJOR REHABILITATION IN NONSPRINKLERED EXISTING HOSPITALS

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	13	17(14)*	8(5)*
2nd or 3rd story	17	19(16)*	10(7)*
4th story or higher	18	19(16)*	11(8)*

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

Step 8 — Identify Zone Fire Safety Equivalency using Worksheet 4.7.9.

(1) Transfer the three circled values from Worksheet 4.7.8A, 4.7.8B, or 4.7.8C to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.

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

WORKSHET 4.7.9 - ZONE FIRE SAFETY EQUIVALENCY EVALUATION

							YES	NO
Containment Safety (S_1)	minus	Mandatory Containment (Sa)	≥ 0	S_1 13	— S_a 2	= C 11	X	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (Sb)	≥ 0	S_2 10	— S_b 10	= E 0	X	
People Movement Safety (S_3)	minus	Mandatory People Movement (Sc)	≥0	S_3 16	— S_c 2	= P 14	X	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 21	— R 1	= G 20	X	

Step 9 — Evaluate other considerations not previously addressed using Worksheet 4.7.10.
Complete one copy of this separate worksheet for each facility.
For each consideration, select and mark the appropriate column.

WORKSHEET 4.7.10 FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	X		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			X
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	X		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	X		
E.	There are no flue-fed incinerators.	X		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	X		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	X		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.			X
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.12 and 19.3.5.12.	X		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	X		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.1.	X		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			X

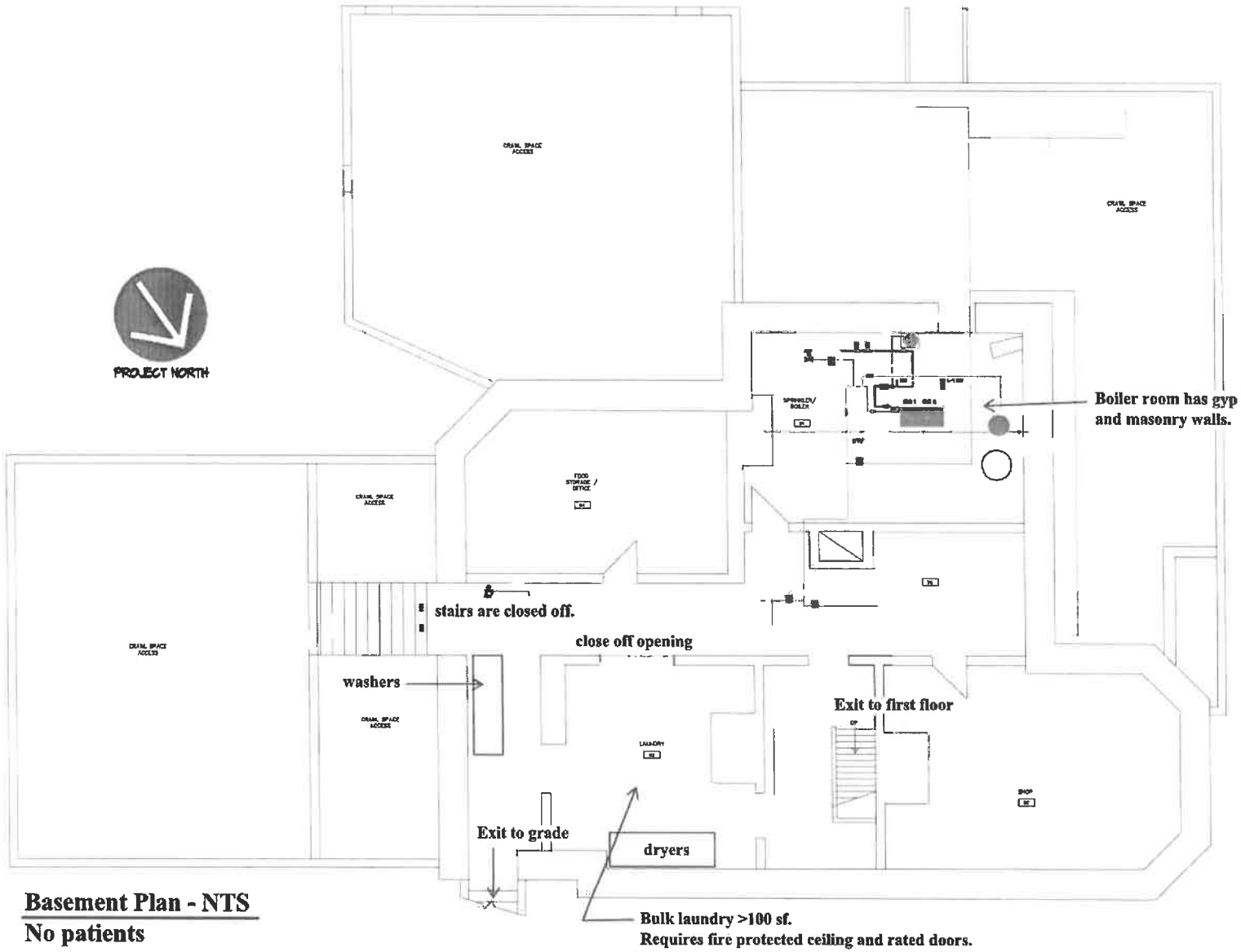
Step 10 — Determine the equivalency Conclusion to determine if the level of life safety is at least equivalent to that prescribed by the Life Safety Code using Worksheet 4.7.11.

WORKSHEET 4.7.11- CONCLUSIONS

1. [X] All of the checks in Worksheet 4.7.9 are in the "Yes" column and all applicable considerations in Worksheet 4.7.10 are marked as "Met". The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

2. [ ] All of the checks in Worksheet 4.7.9 are in the "Yes" column and all considerations in Worksheet 4.7.10 marked as "Not Met" have been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

3. [ ] One or more of the checks on Worksheet 4.7.9 are in the "No" column or any considerations in Worksheet 4.7.10 marked as "Not Met" have NOT been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is not shown by this system to be equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.



Basement Plan - NTS
No patients

The basement requires fire rated doors to separate spaces from corridor.

Ceiling should be non-combustible material vs. wood.

FIRE SAFETY EVALUATION SYSTEM
HEALTH CARE FACILITIES

(NFPA 101A, "Guide on Alternative Approaches to Life Safety" 2013 Edition)

Complete the following worksheets for each fire/smoke zone*.
Where conditions are the same in several zones, one set of worksheets can be used for those zones.
* Fire/smoke zone is a space separated from all other spaces by floors, horizontal exits, or smoke barriers

Step 1 — Complete Cover Sheet using Worksheet 4.7.1.

WORKSHEET 4.7.1 – COVER SHEET

ZONE 5 OF 6 ZONES

Third Floor

NAME OF FACILITY **The Villa Rehab**	ADDRESS OF FACILITY		
ZONE(S) EVALUATED **Zone 5 - Third Floor**			
PROVIDER/VENDOR NO. **EHDanson Associates Architects**	DATE OF SURVEY **September 1, 27, 2022** Revised 11/28 to incorporate JH comments on 11/14.		
SURVEYOR SIGNATURE **Roy Ward** Roy Ward SURVEYOR ID	TITLE **Principal**	OFFICE	DATE
FIRE AUTHORITY SIGNATURE	TITLE	OFFICE	DATE

ADDITIONAL COMMENTS:

The third floor is administrative space only and has no patients.

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

Step 2 — Determine Occupancy Risk Parameter Factors using Worksheet 4.7.2.
For each Risk Parameter in Worksheet 7.2, select and circle the appropriate risk factor value.
Choose only one for each of the five Risk Parameters.

WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factor Values					
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable	
	Risk Factor	(1.0)	1.6	3.2	4.5	
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30	
	Risk Factor	(1.0)	1.2	1.5	2.0	
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	1.1	(1.2)	1.4	1.6	1.6
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	(1.0)	1.1	1.2	1.5	4.0*
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 Year		65 Years and Over or 1 Year and Younger		
	Risk Factor	(1.0)		1.2		

*A risk factor of 4.0 is charged to any zone that houses patients without any staff in immediate attendance.

Step 3 — Compute Occupancy Risk Factor (F) using Worksheet 4.7.3.
(1) Transfer the circled risk factor values from Worksheet 4.7.2 to the corresponding blocks in Worksheet 4.7.3.
(2) Compute F by multiplying the risk factor values as indicated in Worksheet 4.7.3.

WORKSHEET 4.7.3 - OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	[1]	X	[1]	X	[1.2]	X	[1]	X	[1]	=	[1.2]

Step 4 — Compute Adjusted Building Status (R) - Use Worksheets 4.7.4 or 4.7.5.
(1) If building is classified as "NEW" use Worksheet 4.7.4. If building is classified as "Existing" use Worksheet 4.7.5.
(2) Transfer the value of F from Worksheet 4.7.3 to Worksheets 4.7.4 or 4.7.5, as appropriate. Calculate R.
(3) Transfer R to the block labeled R in Worksheet 4.7.9.
(4) In Worksheets 4.7.4 and 4.7.5, results are always rounded up (i.e., 3.2 is rounded to 4.0).

WORKSHEET 4.7.4 ADJUSTED OCCUPANCY RISK FACTOR (NEW)

	F		R
1.0 X	[ ]	=	[ ]

WORKSHEET 4.7.5 ADJUSTED OCCUPANCY RISK FACTOR (EXISTING)

	F		R
0.6 X	[1.2]	=	[1.0]

Step 5 — Determine Safety Parameter Values using Worksheet 4.7.6.

(1) Select and circle the safety value for each safety parameter that best describes the conditions in the zone.
(2) Choose only one value for each of the 13 parameters.
(3) If two or more appear to apply, choose the one with the lowest point value.

WORKSHEET 4.7.6 – SAFETY PARAMETER VALUES

Safety Parameters	Parameters Values						
1. Construction	Combustible Types III, IV, and V				Non-Combustible Types I and II		
Floor or Zone	000	111	200	211, 2HH	000	111	222, 322, 442
First	-2	0	-2	0	0	2	2
Second	-7	-2	-4	-2	-2	2	4
Third	(-9)	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A				
	(-5(0))[f]	0(3)[f]	3				
3. Interior Finish (Rooms)	Class C	Class B	Class A				
	(-3(0))[f]	1(3)[f]	3				
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	>½ to <1 hour	≥1 hour			
	-10(0)[a]	0	(1(0))[a]	2(0)[a]			
5. Doors to Corridor	No Door	<20 min FPR	≥ 20 min FPR	≥ 20 min FPR and Auto Closure			
	-10	(0)	1(0)[d]	2(0)[d]			
6. Zone Dimensions	Dead End			No Dead Ends >30 ft. and Zone Length Is			
	>100 ft.	>50 ft. to 100 ft.	30 ft. to 50 ft.	>150 ft.	100 ft. to 150 ft.	<100 ft.	
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c] (0)[h]	0(0)[h]	(1)	
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resistance				
			<1 hr.	≥1 hr. to <2 hr.	≥2 hr.		
	-14	-10	0	(2(0))	3(0)[e]		
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies		
	In Zone	Outside Zone	In Zone	In Adjacent Zone			
	-11	-5	-6	-2	(0)		
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mechanically Assisted Systems by Zone				
	(-3(0))	0	3				
10. Emergency Movement Routes	<2 Routes	Multiple Routes			Direct Exit(s)		
	-8	Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)			
		-2	(0)	1	5		
11. Manual Fire Alarm	No Manual Fire Alarm	Manual Fire Alarm					
		W/O F.D. Conn.	W/F.D. Conn.				
	-4	1	(2)				
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces in Zone		
	0(3)[g]	2(3)[g]	3(3)[g]	(4)	5		
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building				
	0	8	(10)				

[a] Use (0) where parameter 5 is -10.

[b] Use (0) where parameter 10 is -8.

[c] Use (0) on floor with fewer than 31 patients (existing buildings only).

[d] Use (0) where parameter 4 is -10.

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200").
For SI Units: 1 ft.² = 0.3048 m²

[f] Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.

[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

[h] Use (0) where zone area ≤ 22,500 ft.² and distance from any point to reach a door in smoke barrier is ≤ 200 ft.

Step 6 — Compute Individual Safety Evaluations using Worksheet 4.7.7.

(1) Transfer each of the 13 circled Safety Parameter Values from Worksheet 4.7.6 to every unshaded block in the line with the corresponding Safety Parameter in Worksheet 4.7.7. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Worksheet 4.7.7 as 1/2 the corresponding value circled in Worksheet 4.7.6.

(2) Add the four columns, keeping in mind that any negative numbers deduct.

(3) Transfer the resulting total values for S1, S2, S3, S4 to blocks labeled S1, S2, S3, S4 in Worksheet 4.7.9 on page 4 of this sheet.

WORKSHEET 4.7.7 - INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-9	-9		-9
2. Interior Finish (Corr. and Exit)	-5		-5	-5
3. Interior Finish (Rooms)	-3			-3
4. Corridor Partitions and Walls	1			1
5. Doors to Corridor	0		0	0
6. Zone Dimensions			1	1
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		4	4	4
13. Automatic Sprinklers	10	10	$10 \div 2 = 5$	10
Total Value	S_1= -6	S_2= 7	S_3= 5	S_4= 1

Step 7 — Determine Mandatory Safety Requirement values using Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(1) Using the facility type (i.e., Hospital or Nursing Home), classification (i.e., New, Existing or Rehabilitated) and the floor where the zone is located, circle the appropriate value in each of the three columns found in Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(2) Transfer the three circled values to the blocks marked S_a, S_b, and S_c in Worksheet 4.7.9.

(3) The Mandatory Safety Requirement value for basements are based on the distance of the basement level from the closest level of discharge (See 4.6.1.2 and 4.6.1.3).

WORKSHEET 4.7.8A - MANDATORY SAFETY REQUIREMENTS – NEW HOSPITALS, EXISTING HOSPITALS OR NEW NURSING HOMES

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Existing	New	Existing	New	Existing
1st story	11	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher, but not high rise	18	9	19(16)[a]	6	11(8)[a]	3
High rise	18	17	19(16)[a]	16	11(8)[a]	7

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

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

WORKSHEET 4.7.8B - MANDATORY SAFETY REQUIREMENTS – EXISTING NURSING HOMES

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	0	10	0
2nd story	2	10	2
3rd story	(6)	(14)	(2)
4th story or higher	8	16	2

WORKSHEET 4.7.8C - MANDATORY SAFETY REQUIREMENTS – MAJOR REHABILITATION IN NONSPRINKLERED EXISTING HOSPITALS

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	13	17(14)*	8(5)*
2nd or 3rd story	17	19(16)*	10(7)*
4th story or higher	18	19(16)*	11(8)*

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

Step 8 — Identify Zone Fire Safety Equivalency using Worksheet 4.7.9.

(1) Transfer the three circled values from Worksheet 4.7.8A, 4.7.8B, or 4.7.8C to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.

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

WORKSHET 4.7.9 - ZONE FIRE SAFETY EQUIVALENCY EVALUATION

							YES	NO
Containment Safety (S_1)	minus	Mandatory Containment (Sa)	≥ 0	S_1 [-6]	— S_a [6]	= C [-12]		X
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (Sb)	≥ 0	S_2 [7]	— S_b [14]	= E [-7]		X
People Movement Safety (S_3)	minus	Mandatory People Movement (Sc)	≥0	S_3 [5]	— S_c [2]	= P [3]	X	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 [1]	— R [1]	= G [0]	X	

Step 9 — Evaluate other considerations not previously addressed using Worksheet 4.7.10.
Complete one copy of this separate worksheet for each facility.
For each consideration, select and mark the appropriate column.

WORKSHEET 4.7.10 FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	X		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			X
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	X		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	X		
E.	There are no flue-fed incinerators.	X		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	X		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	X		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.		X	
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.12 and 19.3.5.12.	X		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	X		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.1.	X		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			X

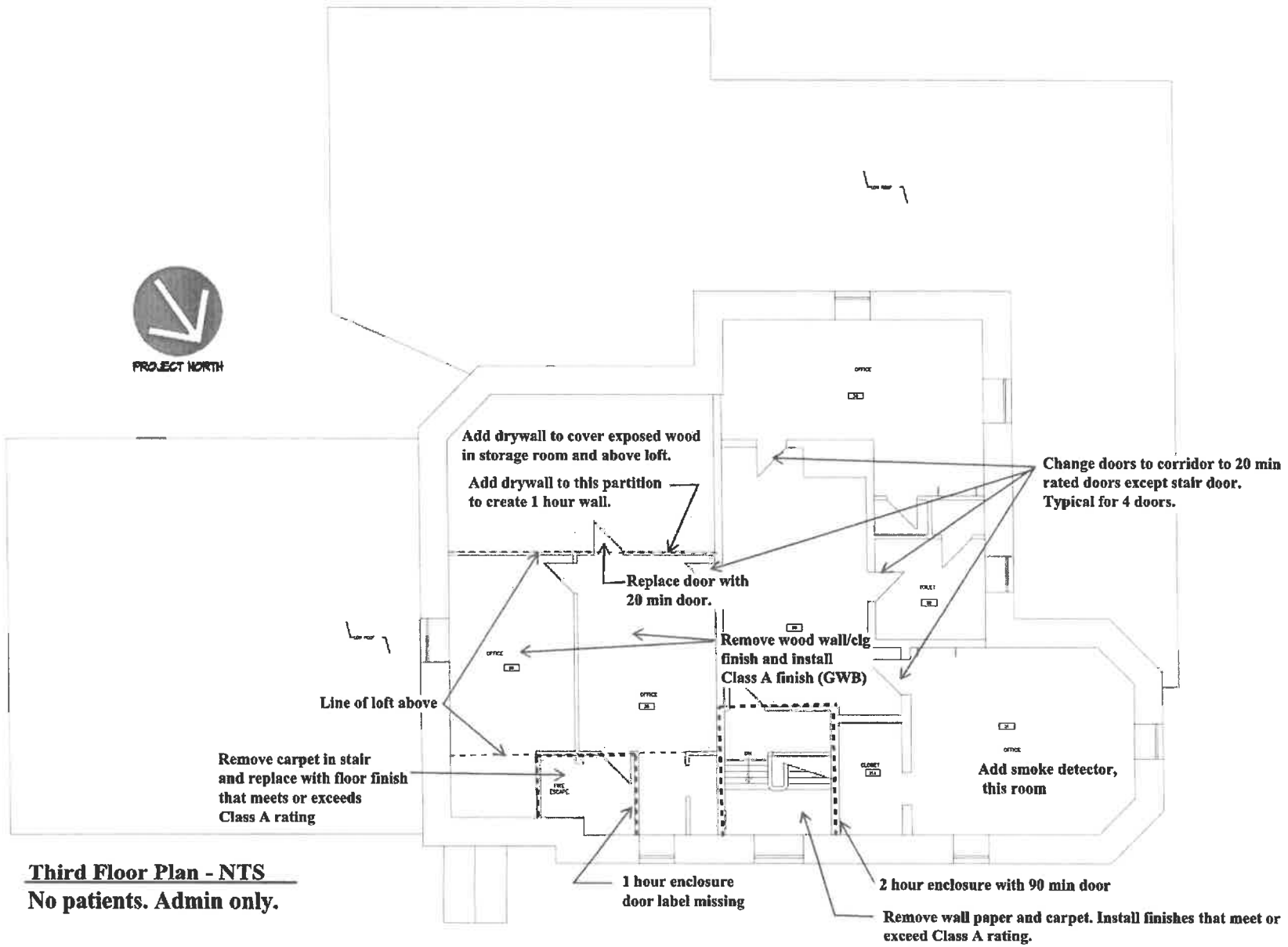
Step 10 — Determine the equivalency Conclusion to determine if the level of life safety is at least equivalent to that prescribed by the Life Safety Code using Worksheet 4.7.11.

WORKSHEET 4.7.11- CONCLUSIONS

1. ☐ All of the checks in Worksheet 4.7.9 are in the "Yes" column and all applicable considerations in Worksheet 4.7.10 are marked as "Met". The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

2. ☐ All of the checks in Worksheet 4.7.9 are in the "Yes" column and all considerations in Worksheet 4.7.10 marked as "Not Met" have been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

3. ☒ One or more of the checks on Worksheet 4.7.9 are in the "No" column or any considerations in Worksheet 4.7.10 marked as "Not Met" have NOT been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is not shown by this system to be equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.



Third Floor Plan - NTS

No patients. Admin only.

FIRE SAFETY EVALUATION SYSTEM
HEALTH CARE FACILITIES

(NFPA 101A, "Guide on Alternative Approaches to Life Safety" 2013 Edition)

Complete the following worksheets for each fire/smoke zone*.
Where conditions are the same in several zones, one set of worksheets can be used for those zones.
* Fire/smoke zone is a space separated from all other spaces by floors, horizontal exits, or smoke barriers

Step 1 — Complete Cover Sheet using Worksheet 4.7.1.

WORKSHEET 4.7.1 – COVER SHEET

ZONE 4 OF 6 ZONES

Second Floor

NAME OF FACILITY	ADDRESS OF FACILITY		
The Villa Rehab			
ZONE(S) EVALUATED			
Zone 4 - Second Floor			
PROVIDER/VENDOR NO.	DATE OF SURVEY		
EHDanson Associates Architects	**September 1, 27, 2022** Revised 11/28 to incorporate JH comments on 11/14.		
SURVEYOR SIGNATURE	TITLE	OFFICE	DATE
Roy Ward Roy Ward	**Principal**		
SURVEYOR ID			
FIRE AUTHORITY SIGNATURE	TITLE	OFFICE	DATE

ADDITIONAL COMMENTS:

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

Step 2 — Determine Occupancy Risk Parameter Factors using Worksheet 4.7.2.
For each Risk Parameter in Worksheet 7.2, select and circle the appropriate risk factor value.
Choose only one for each of the five Risk Parameters.

WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factor Values					
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable	
	Risk Factor	1.0	1.6	(3.2)	4.5	
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30	
	Risk Factor	1.0	(1.2)	1.5	2.0	
3. Zone Location *(L)*	Floor	1st	(2nd or 3rd)	4th to 6th	7th and Above	Basements
	Risk Factor	1.1	(1.2)	1.4	1.6	1.6
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0	1.1	(1.2)	1.5	4.0*
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 Year		65 Years and Over or 1 Year and Younger		
	Risk Factor	1.0		(1.2)		

*A risk factor of 4.0 is charged to any zone that houses patients without any staff in immediate attendance.

Step 3 — Compute Occupancy Risk Factor (F) using Worksheet 4.7.3.
(1) Transfer the circled risk factor values from Worksheet 4.7.2 to the corresponding blocks in Worksheet 4.7.3.
(2) Compute F by multiplying the risk factor values as indicated in Worksheet 4.7.3.

WORKSHEET 4.7.3 - OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	1.2	X	1.2	X	1.2	X	1.2	=	6.7

Step 4 — Compute Adjusted Building Status (R) - Use Worksheets 4.7.4 or 4.7.5.
(1) If building is classified as "NEW" use Worksheet 4.7.4. If building is classified as "Existing" use Worksheet 4.7.5.
(2) Transfer the value of F from Worksheet 4.7.3 to Worksheets 4.7.4 or 4.7.5, as appropriate. Calculate R.
(3) Transfer R to the block labeled R in Worksheet 4.7.9.
(4) In Worksheets 4.7.4 and 4.7.5, results are always rounded up (i.e., 3.2 is rounded to 4.0).

WORKSHEET 4.7.4 ADJUSTED OCCUPANCY RISK FACTOR (NEW)

	F		R
1.0 X		=	

WORKSHEET 4.7.5 ADJUSTED OCCUPANCY RISK FACTOR (EXISTING)

	F		R
0.6 X	6.7	=	4.0

Step 5 — Determine Safety Parameter Values using Worksheet 4.7.6.

(1) Select and circle the safety value for each safety parameter that best describes the conditions in the zone.
(2) Choose only one value for each of the 13 parameters.
(3) If two or more appear to apply, choose the one with the lowest point value.

WORKSHEET 4.7.6 – SAFETY PARAMETER VALUES

Safety Parameters	Parameters Values						
1. Construction	Combustible Types III, IV, and V				Non-Combustible Types I and II		
Floor or Zone	000	111	200	211, 2HH	000	111	222, 322, 442
First	-2	0	-2	0	0	2	2
Second	(-7)	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4

2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A			
	(-5(0))	0(3)[f]	3			
3. Interior Finish (Rooms)	Class C	Class B	Class A			
	(-3(1))	1(3)[f]	3			
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	>½ to <1 hour	≥1 hour		
	-10(0)[a]	0	1(0)[a]	(2(0))		
5. Doors to Corridor	No Door	<20 min FPR	≥ 20 min FPR	≥ 20 min FPR and Auto Closure		
	-10	(0)	1(0)[d]	2(0)[d]		

6. Zone Dimensions	Dead End			No Dead Ends >30 ft. and Zone Length Is		
	>100 ft.	>50 ft. to 100 ft.	30 ft. to 50 ft.	>150 ft.	100 ft. to 150 ft.	<100 ft.
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c] (0)[h]	0(0)[h]	(1)

7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resistance		
			<1 hr.	≥1 hr. to <2 hr.	≥2 hr.
	-14	-10	0	(2(0)[e])	3(0)[e]

8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies
	In Zone	Outside Zone	In Zone	In Adjacent Zone	
	-11	-5	-6	-2	(0)

9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mechanically Assisted Systems by Zone	
	(-5(0))	0	3	

10. Emergency Movement Routes	<2 Routes	Multiple Routes			Direct Exit(s)
	-8	Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	
		-2	(0)	1	5

11. Manual Fire Alarm	No Manual Fire Alarm	Manual Fire Alarm	
		W/O F.D. Conn.	W/F.D. Conn.
	-4	1	(2)

12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces in Zone
	0(3)[g]	2(3)[g]	3(3)[g]	(4)	5

13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building	
	0	8	(10)	

[a] Use (0) where parameter 5 is -10.

[b] Use (0) where parameter 10 is -8.

[c] Use (0) on floor with fewer than 31 patients (existing buildings only).

[d] Use (0) where parameter 4 is -10.

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200").
For SI Units: 1 ft.² = 0.3048 m²

[f] Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.

[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

[h] Use (0) where zone area ≤ 22,500 ft.² and distance from any point to reach a door in smoke barrier is ≤ 200 ft.

Step 6 — Compute Individual Safety Evaluations using Worksheet 4.7.7.

(1) Transfer each of the 13 circled Safety Parameter Values from Worksheet 4.7.6 to every unshaded block in the line with the corresponding Safety Parameter in Worksheet 4.7.7. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Worksheet 4.7.7 as 1/2 the corresponding value circled in Worksheet 4.7.6.

(2) Add the four columns, keeping in mind that any negative numbers deduct.

(3) Transfer the resulting total values for S1, S2, S3, S4 to blocks labeled S1, S2, S3, S4 in Worksheet 4.7.9 on page 4 of this sheet.

WORKSHEET 4.7.7 - INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-7	-7		-7
2. Interior Finish (Corr. and Exit)	-5		-5	-5
3. Interior Finish (Rooms)	-3			-3
4. Corridor Partitions and Walls	2			2
5. Doors to Corridor	0		0	0
6. Zone Dimensions			1	1
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		4	4	4
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= -3	S_2= 9	S_3= 5	S_4= 4

Step 7 — Determine Mandatory Safety Requirement values using Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(1) Using the facility type (i.e., Hospital or Nursing Home), classification (i.e., New, Existing or Rehabilitated) and the floor where the zone is located, circle the appropriate value in each of the three columns found in Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(2) Transfer the three circled values to the blocks marked S_a, S_b, and S_c in Worksheet 4.7.9.

(3) The Mandatory Safety Requirement value for basements are based on the distance of the basement level from the closest level of discharge (See 4.6.1.2 and 4.6.1.3).

WORKSHEET 4.7.8A - MANDATORY SAFETY REQUIREMENTS – NEW HOSPITALS, EXISTING HOSPITALS OR NEW NURSING HOMES

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Existing	New	Existing	New	Existing
1st story	11	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher, but not high rise	18	9	19(16)[a]	6	11(8)[a]	3
High rise	18	17	19(16)[a]	16	11(8)[a]	7

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

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

WORKSHEET 4.7.8B - MANDATORY SAFETY REQUIREMENTS – EXISTING NURSING HOMES

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	0	10	0
2nd story	(2)	(10)	(2)
3rd story	6	14	2
4th story or higher	8	16	2

WORKSHEET 4.7.8C - MANDATORY SAFETY REQUIREMENTS – MAJOR REHABILITATION IN NONSPRINKLERED EXISTING HOSPITALS

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	13	17(14)*	8(5)*
2nd or 3rd story	17	19(16)*	10(7)*
4th story or higher	18	19(16)*	11(8)*

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

Step 8 — Identify Zone Fire Safety Equivalency using Worksheet 4.7.9.

(1) Transfer the three circled values from Worksheet 4.7.8A, 4.7.8B, or 4.7.8C to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.

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

WORKSHET 4.7.9 - ZONE FIRE SAFETY EQUIVALENCY EVALUATION

							YES	NO
Containment Safety (S_1)	minus	Mandatory Containment (Sa)	≥ 0	S_1 -3	S_a 2	C = -5		X
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (Sb)	≥ 0	S_2 9	S_b 10	E = -1		X
People Movement Safety (S_3)	minus	Mandatory People Movement (Sc)	≥0	S_3 5	S_c 2	P = 3	X	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 4	R 4	G = 0	X	

Step 9 — Evaluate other considerations not previously addressed using Worksheet 4.7.10.
Complete one copy of this separate worksheet for each facility.
For each consideration, select and mark the appropriate column.

WORKSHEET 4.7.10 FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	X		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			X
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	X		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	X		
E.	There are no flue-fed incinerators.	X		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	X		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	X		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.		X	
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.12 and 19.3.5.12.	X		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	X		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.1.	X		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			X

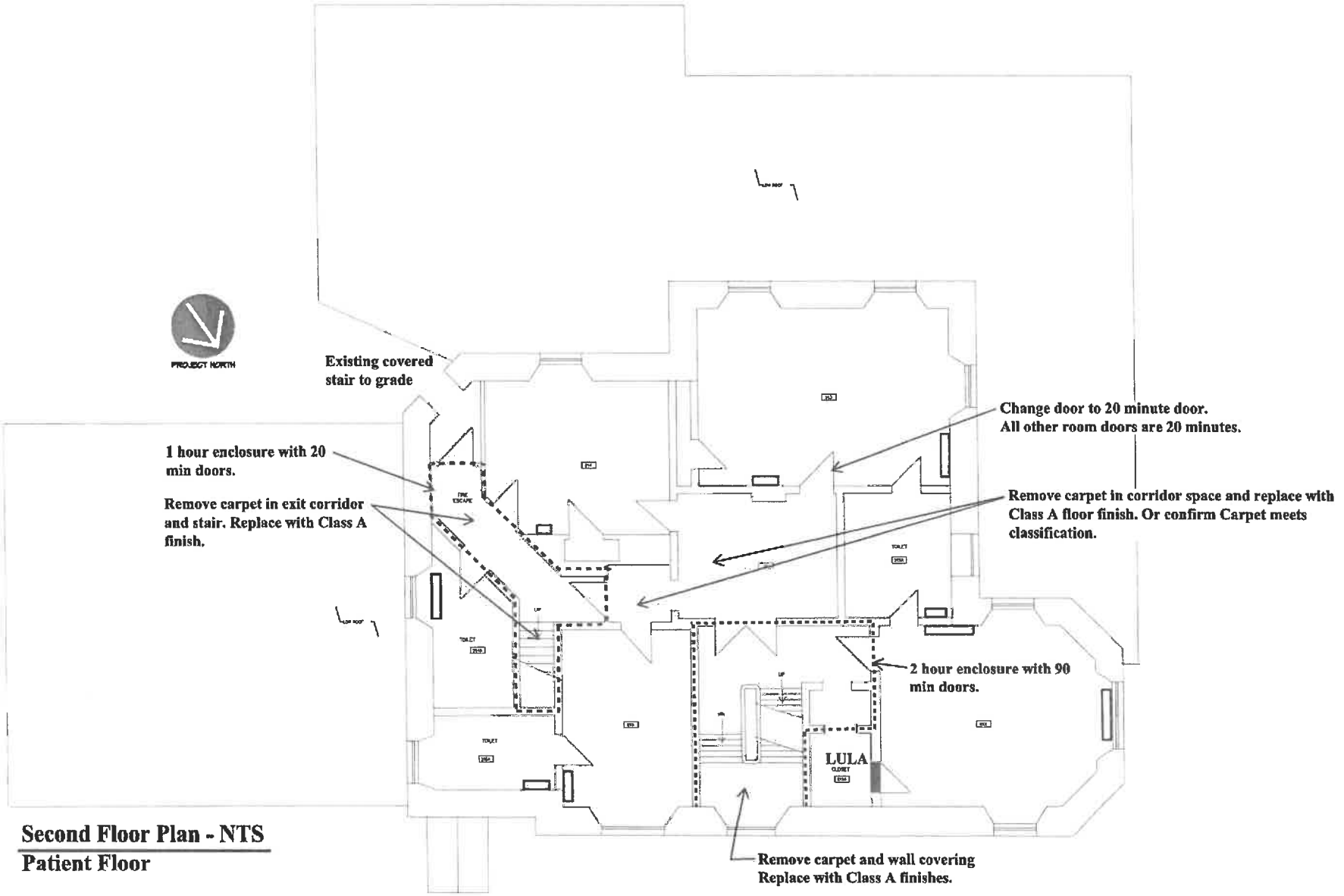
Step 10 — Determine the equivalency Conclusion to determine if the level of life safety is at least equivalent to that prescribed by the Life Safety Code using Worksheet 4.7.11.

WORKSHEET 4.7.11- CONCLUSIONS

1. ☐ All of the checks in Worksheet 4.7.9 are in the "Yes" column and all applicable considerations in Worksheet 4.7.10 are marked as "Met". The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

2. ☐ All of the checks in Worksheet 4.7.9 are in the "Yes" column and all considerations in Worksheet 4.7.10 marked as "Not Met" have been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

3. ☒ One or more of the checks on Worksheet 4.7.9 are in the "No" column or any considerations in Worksheet 4.7.10 marked as "Not Met" have NOT been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is not shown by this system to be equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.



Second Floor Plan - NTS

Patient Floor

FIRE SAFETY EVALUATION SYSTEM
HEALTH CARE FACILITIES

(NFPA 101A, "Guide on Alternative Approaches to Life Safety" 2013 Edition)

Complete the following worksheets for each fire/smoke zone*.
Where conditions are the same in several zones, one set of worksheets can be used for those zones.
* Fire/smoke zone is a space separated from all other spaces by floors, horizontal exits, or smoke barriers

Step 1 — Complete Cover Sheet using Worksheet 4.7.1.

WORKSHEET 4.7.1 – COVER SHEET

ZONE 6 OF 6 ZONES

Basement

NAME OF FACILITY	ADDRESS OF FACILITY		
The Villa Rehab			
ZONE(S) EVALUATED			
6 of 6 Basement			
PROVIDER/VENDOR NO.	DATE OF SURVEY		
EHDanson Associate Architects	**September 1, 27, 2022** Revised 11/28 to incorporate JH comments on 11/14.		
SURVEYOR SIGNATURE	TITLE	OFFICE	DATE
Roy Ward Roy Ward	**Principal**		
SURVEYOR ID			
FIRE AUTHORITY SIGNATURE	TITLE	OFFICE	DATE

ADDITIONAL COMMENTS:

There are no patients in the basement.

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

Step 2 — Determine Occupancy Risk Parameter Factors using Worksheet 4.7.2.
For each Risk Parameter in Worksheet 7.2, select and circle the appropriate risk factor value.
Choose only one for each of the five Risk Parameters.

WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factor Values					
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable	
	Risk Factor	(1.0)	1.6	3.2	4.5	
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30	
	Risk Factor	(1.0)	1.2	1.5	2.0	
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	1.1	1.2	1.4	1.6	(1.6)
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	(1.0)	1.1	1.2	1.5	4.0*
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 Year		65 Years and Over or 1 Year and Younger		
	Risk Factor	(1.0)		1.2		

*A risk factor of 4.0 is charged to any zone that houses patients without any staff in immediate attendance.

Step 3 — Compute Occupancy Risk Factor (F) using Worksheet 4.7.3.
(1) Transfer the circled risk factor values from Worksheet 4.7.2 to the corresponding blocks in Worksheet 4.7.3.
(2) Compute F by multiplying the risk factor values as indicated in Worksheet 4.7.3.

WORKSHEET 4.7.3 - OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	1.0	X	1.0	X	1.6	X	1.0	X	1.0	=	1.6

Step 4 — Compute Adjusted Building Status (R) - Use Worksheets 4.7.4 or 4.7.5.
(1) If building is classified as "NEW" use Worksheet 4.7.4. If building is classified as "Existing" use Worksheet 4.7.5.
(2) Transfer the value of F from Worksheet 4.7.3 to Worksheets 4.7.4 or 4.7.5, as appropriate. Calculate R.
(3) Transfer R to the block labeled R in Worksheet 4.7.9.
(4) In Worksheets 4.7.4 and 4.7.5, results are always rounded up (i.e., 3.2 is rounded to 4.0).

WORKSHEET 4.7.4 ADJUSTED OCCUPANCY RISK FACTOR (NEW)

	F		R
1.0 X		=	

WORKSHEET 4.7.5 ADJUSTED OCCUPANCY RISK FACTOR (EXISTING)

	F		R	
0.6 X	1.6	=	.96	(1)

Step 5 — Determine Safety Parameter Values using Worksheet 4.7.6.

(1) Select and circle the safety value for each safety parameter that best describes the conditions in the zone.
(2) Choose only one value for each of the 13 parameters.
(3) If two or more appear to apply, choose the one with the lowest point value.

WORKSHEET 4.7.6 – SAFETY PARAMETER VALUES

Safety Parameters	Parameters Values						
1. Construction	Combustible Types III, IV, and V				Non-Combustible Types I and II		
Floor or Zone	000	111	200	211, 2HH	000	111	222, 322, 442
First	-2	0	-2	0	0	2	2
Second	(-7)	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A				
	(-5(0))	0(3)[f]	3				
3. Interior Finish (Rooms)	Class C	Class B	Class A				
	(-3(1))	1(3)[f]	3				
4. Corridor Partitions/Walls	None or Incomplete	<1/2 hour	>1/2 to <1 hour	≥1 hour			
	-10(0)[a]	0	1(0)[a]	(2(0)[a])			
5. Doors to Corridor	No Door	<20 min FPR	≥ 20 min FPR	≥ 20 min FPR and Auto Closure			
	(-10)	0	1(0)[d]	2(0)[d]			
6. Zone Dimensions	Dead End			No Dead Ends >30 ft. and Zone Length Is			
	>100 ft.	>50 ft. to 100 ft.	30 ft. to 50 ft.	>150 ft.	100 ft. to 150 ft.	<100 ft.	
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c] (0)[h]	0(0)[h]	(1)	
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resistance				
			<1 hr.	≥1 hr. to <2 hr.	≥2 hr.		
	-14	-10	(0)	2(0)[e]	3(0)[e]		
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies		
	In Zone	Outside Zone	In Zone	In Adjacent Zone			
	-11	-5	(-6)	-2	0		
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mechanically Assisted Systems by Zone				
	(-5(0)[b])	0	3				
10. Emergency Movement Routes	<2 Routes	Multiple Routes			Direct Exit(s)		
	-8	Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)			
		-2	(0)	1	5		
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm				
			W/O F.D. Conn.	W/F.D. Conn.			
	-4		1	(2)			
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces in Zone		
	0(3)[g]	(2(3)[f])	3(3)[g]	4	5		
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building				
	0	8	(10)				

[a] Use (0) where parameter 5 is -10.

[b] Use (0) where parameter 10 is -8.

[c] Use (0) on floor with fewer than 31 patients (existing buildings only).

[d] Use (0) where parameter 4 is -10.

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200").
For SI Units: 1 ft.² = 0.3048 m²

[f] Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.

[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

[h] Use (0) where zone area ≤ 22,500 ft.² and distance from any point to reach a door in smoke barrier is ≤ 200 ft.

Step 6 — Compute Individual Safety Evaluations using Worksheet 4.7.7.

(1) Transfer each of the 13 circled Safety Parameter Values from Worksheet 4.7.6 to every unshaded block in the line with the corresponding Safety Parameter in Worksheet 4.7.7. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Worksheet 4.7.7 as 1/2 the corresponding value circled in Worksheet 4.7.6.

(2) Add the four columns, keeping in mind that any negative numbers deduct.

(3) Transfer the resulting total values for S1, S2, S3, S4 to blocks labeled S1, S2, S3, S4 in Worksheet 4.7.9 on page 4 of this sheet.

WORKSHEET 4.7.7 - INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-7	-7		-7
2. Interior Finish (Corr. and Exit)	-5		-5	-5
3. Interior Finish (Rooms)	-3			-3
4. Corridor Partitions and Walls	0			0
5. Doors to Corridor	-10		-10	-10
6. Zone Dimensions			1	1
7. Vertical Openings	0		0	0
8. Hazardous Areas	-6	-6		-6
9. Smoke Control			0	0
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		2	2	2
13. Automatic Sprinklers	10	10	10 · 2 = 5	10
Total Value	S_1= -21	S_2= 1	S_3= -7	S_4= -16

Step 7 — Determine Mandatory Safety Requirement values using Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(1) Using the facility type (i.e., Hospital or Nursing Home), classification (i.e., New, Existing or Rehabilitated) and the floor where the zone is located, circle the appropriate value in each of the three columns found in Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(2) Transfer the three circled values to the blocks marked S_a, S_b, and S_c in Worksheet 4.7.9.

(3) The Mandatory Safety Requirement value for basements are based on the distance of the basement level from the closest level of discharge (See 4.6.1.2 and 4.6.1.3).

WORKSHEET 4.7.8A - MANDATORY SAFETY REQUIREMENTS – NEW HOSPITALS, EXISTING HOSPITALS OR NEW NURSING HOMES

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Existing	New	Existing	New	Existing
1st story	11	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher, but not high rise	18	9	19(16)[a]	6	11(8)[a]	3
High rise	18	17	19(16)[a]	16	11(8)[a]	7

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

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

WORKSHEET 4.7.8B - MANDATORY SAFETY REQUIREMENTS – EXISTING NURSING HOMES

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	0	10	0
2nd story	(2)	(10)	(2)
3rd story	6	14	2
4th story or higher	8	16	2

WORKSHEET 4.7.8C - MANDATORY SAFETY REQUIREMENTS – MAJOR REHABILITATION IN NONSPRINKLERED EXISTING HOSPITALS

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	13	17(14)*	8(5)*
2nd or 3rd story	17	19(16)*	10(7)*
4th story or higher	18	19(16)*	11(8)*

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

Step 8 — Identify Zone Fire Safety Equivalency using Worksheet 4.7.9.

(1) Transfer the three circled values from Worksheet 4.7.8A, 4.7.8B, or 4.7.8C to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.

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

WORKSHET 4.7.9 - ZONE FIRE SAFETY EQUIVALENCY EVALUATION

							YES	NO
Containment Safety (S_1)	minus	Mandatory Containment (Sa)	≥ 0	S_1 -21	— S_a 2	= C -23		X
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (Sb)	≥ 0	S_2 1	— S_b 10	= E -9		X
People Movement Safety (S_3)	minus	Mandatory People Movement (Sc)	≥0	S_3 -7	— S_c 2	= P -9		X
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 -16	— R 1	= G -17		X

Step 9 — Evaluate other considerations not previously addressed using Worksheet 4.7.10.
Complete one copy of this separate worksheet for each facility.
For each consideration, select and mark the appropriate column.

WORKSHEET 4.7.10 FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	X		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			X
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	X		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	X		
E.	There are no flue-fed incinerators.	X		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	X		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	X		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.			X
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.12 and 19.3.5.12.	X		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	X		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.1.	X		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			X

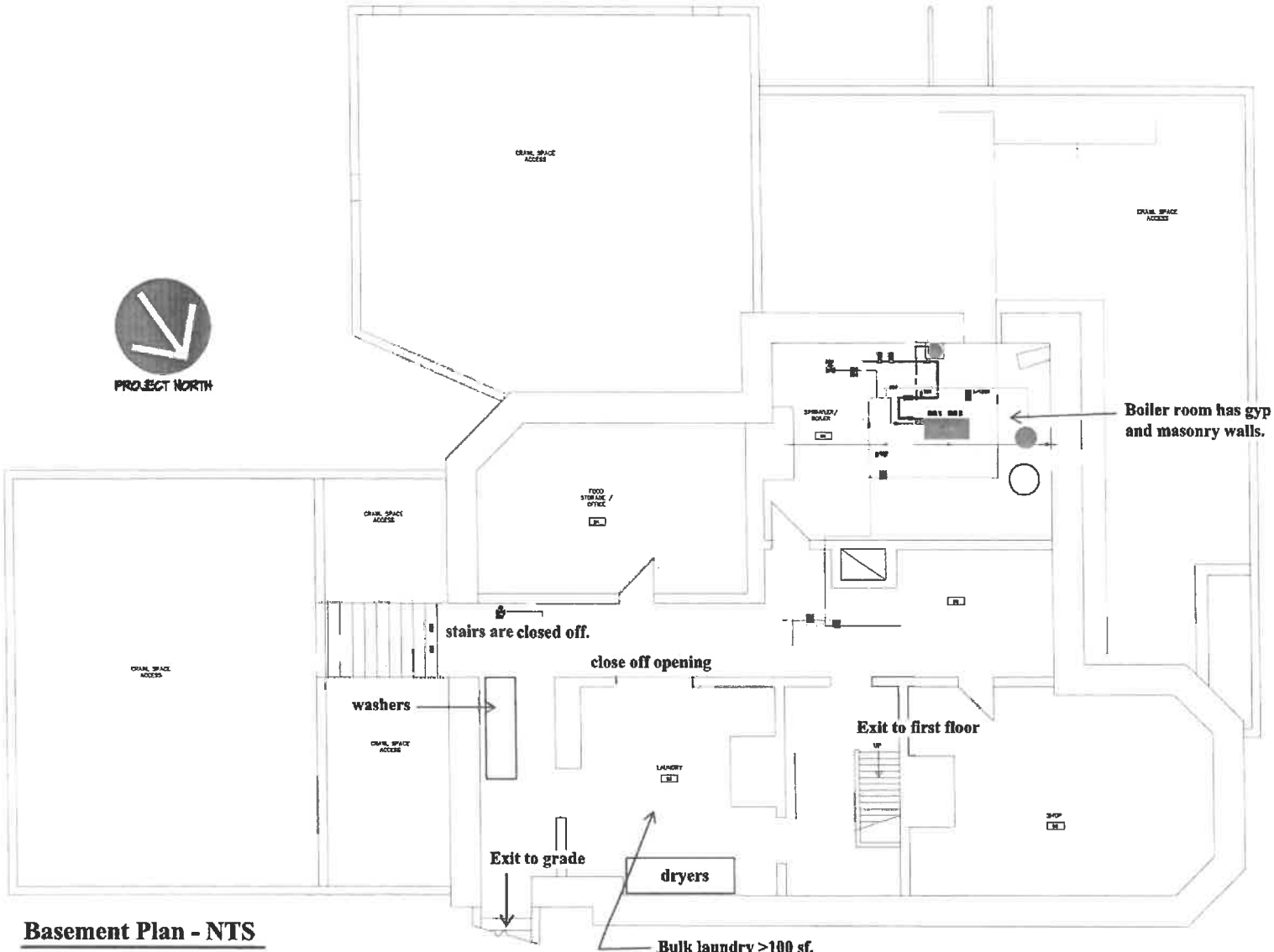
Step 10 — Determine the equivalency Conclusion to determine if the level of life safety is at least equivalent to that prescribed by the Life Safety Code using Worksheet 4.7.11.

WORKSHEET 4.7.11- CONCLUSIONS

1. ☐ All of the checks in Worksheet 4.7.9 are in the "Yes" column and all applicable considerations in Worksheet 4.7.10 are marked as "Met". The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

2. ☐ All of the checks in Worksheet 4.7.9 are in the "Yes" column and all considerations in Worksheet 4.7.10 marked as "Not Met" have been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

3. ☒ One or more of the checks on Worksheet 4.7.9 are in the "No" column or any considerations in Worksheet 4.7.10 marked as "Not Met" have NOT been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is not shown by this system to be equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.



Basement Plan - NTS
No patients

The basement requires fire rated doors to separate spaces from corridor.

Ceiling should be non-combustible material vs. wood.

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line (888) 700-5330
To Report Adult Abuse: (800) 564-1612

July 13, 2022

Ms. April Furlow, Administrator
The Villa Rehab
7 Forest Hill Drive
St Albans, VT 05478-1615

Provider ID #: 475055

Dear Ms. Furlow:

The Division of Fire Safety completed a **Life Safety Code survey** at your facility on **May 31, 2022**. The purpose of the survey was to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and Medicaid programs. This survey found that your facility was in substantial compliance with the participation requirements. **However, there is one deficiency that does not require a plan of correction but does require a commitment to correct.** All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations. Please **sign the enclosed CMS-2567 and return** the original to this office by **July 23, 2022**.

Informal Dispute Resolution
In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, 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 Suzanne Leavitt, RN, MS, Assistant Division Director, Division of Licensing and Protection. This request must be sent during the same ten days you have for returning the enclosed CMS-2567 statement of deficiencies. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Sincerely,

Pamela M Cota RN

Pamela Cota RN
Licensing Chief

Enclosure

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	475055	A. BUILDING: 01 B. WING _____	5/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA REHAB	7 FOREST HILL DRIVE ST ALBANS, VT

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 211	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Per observation on May 31, 2022, the facility failed to ensure that all means of egress are free of obstructions and maintained in accordance with Chapter 7. Findings include the following: 1. Per observation on May 31, 2022, inspection revealed that the exit door leading to the exterior of the building from hallway three was dragging on the exterior threshold, making it difficult to open. 2. Per observation on May 31, 2022, inspection revealed that a portion of the staff-only basement stairwell lacks balusters or any other fall prevention.

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

The above isolated deficiencies pose no actual harm to the residents

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line (888) 700-5330
To Report Adult Abuse: (800) 564-1612

February 12, 2020

Ms. April Furlow, Administrator
The Villa Rehab
7 Forest Hill Drive
St Albans, VT 05478-1615

Provider ID #: 475055

Dear Ms. Furlow:

The Division of Fire Safety completed a survey at your facility on **January 30, 2020.** The purpose of the survey was to determine if your facility was in compliance with Life Safety Code Federal participation requirements for nursing homes participating in the Medicare and Medicaid programs. This survey found that your facility was in substantial compliance with the participation requirements. However, there are five deficiencies that that require a plan of correction. Please submit the your plan of correction on the enclosed CMS-2567 and return the original to this office by **February 22, 2020.**

Plan of Correction (POC)
A written POC for all of the deficiencies, which is your allegation of compliance, must be received by **February 22, 2020.** Failure to submit an acceptable POC by **February 22, 2020** may result in imposition of additional remedies or termination of your provider certification. Your POC must contain the following:

- What corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: and,
- How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.
- The dates corrective action will be completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475055	A. BUILDING 01 - BUILDING 01 B. WING	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA REHAB	7 FOREST HILL DRIVE ST ALBANS, VT 05478

(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 An unannounced onsite Life Safety Code inspection was completed by the Division of Fire Safety on January 30, 2020. The following violations were identified.	K 000		
K 311 SS=B	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Per observation on January 30, 2020, the facility failed to ensure that stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. Per observation on January 30, 2020, inspection revealed that the second floor stairway door did not latch from every position.	K 311		
K 353 SS=B	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance	K 353		

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

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
	475055	A. BUILDING 01 - BUILDING 01 B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA REHAB	7 FOREST HILL DRIVE ST ALBANS, VT 05478

(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 362	Continued From page 3 Per observation on January 30, 2020, the facility failed to ensure corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. Findings include the following: Per observation on January 30, 2020, inspection revealed the corridor closet near the kitchen did not have the required sealing of a penetration.	K 362		
K 511 SS=B	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Per observation on January 30, 2020, the facility failed to ensure that equipment using gas or related to gas piping complies with NFPA 54, National Fuel Gas Code, and that electrical wiring and equipment complies with NFPA 70, National Electric Code. Findings include the following: Per observation on January 30, 2020, inspection revealed that a receptacle was damaged in the dining room (the ground portion was slightly cracked).	K 511		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475055	A. BUILDING 01 - BUILDING 01 B. WING	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA REHAB	7 FOREST HILL DRIVE ST ALBANS, VT 05478

(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 An unannounced onsite Life Safety Code inspection was completed by the Division of Fire Safety on January 30, 2020. The following violations were identified.	K 000		
K 311 SS=B	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Per observation on January 30, 2020, the facility failed to ensure that stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. Per observation on January 30, 2020, inspection revealed that the second floor stairway door did not latch from every position.	K 311	**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** Maintenance staff have been re-educated on policies regarding fire door audits. Fire door audits are to be completed monthly. **How the corrective actions will be monitored to ensure the deficient practice will not recur?** Maintenance staff will reviewed findings of fire door audits monthly with NHA for compliance. **The dates corrective action will be completed.** Corrective action was completed on 01/30/2020.	
K 353 SS=B	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: April [signature], NHA   TITLE   (X6) DATE 2/18/2020

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
	475055	A. BUILDING 01 - BUILDING 01 B. WING	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA REHAB	7 FOREST HILL DRIVE ST ALBANS, VT 05478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 1 with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Per observation on January 30, 2020, the facility failed to ensure automatic sprinkler and standpipe systems are inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Findings include the following: Per observation on January 30, 2020, inspection revealed an escutcheon missing from the sprinkler head in break area.	K 353	**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** Maintenance staff have been re-educated on policies regarding sprinkler audits. Sprinkler audits are to be completed monthly. **How the corrective actions will be monitored to ensure the deficient practice will not recur?** Maintenance staff will reviewed findings of sprinkler audits monthly with NHA for compliance. **The dates corrective action will be completed.** Corrective action was completed on 01/30/2020.	
K 355 SS=B	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475055	A. BUILDING 01 - BUILDING 01 B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA REHAB	7 FOREST HILL DRIVE ST ALBANS, VT 05478

(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 355 Continued From page 2

This REQUIREMENT is not met as evidenced by:

Per observation on January 30, 2020, the facility failed to ensure portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers..

Per observation on January 30, 2020, inspection revealed that access to a fire extinguisher near the nurse's station was blocked by two 'wet floor' signs.

K 362 SS=B Corridors - Construction of Walls
CFR(s): NFPA 101

Corridors - Construction of Walls
2012 EXISTING
Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code.
Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames.
If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area.
19.3.6.2, 19.3.6.2.7
This REQUIREMENT is not met as evidenced by:

K 355 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.**

Housekeeping and Maintenance staff have been re-educated on policies regarding fire safety, to include access to fire extinguishers. Monthly audits of fire extinguishers will be completed by Maintenance staff.

How the corrective actions will be monitored to ensure the deficient practice will not recur?

Maintenance staff will reviewed findings of fire extinguisher audits monthly with NHA for compliance.

The dates corrective action will be completed.

Corrective action was completed on 01/30/2020.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475055	A. BUILDING 01 - BUILDING 01 B. WING	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA REHAB	7 FOREST HILL DRIVE ST ALBANS, VT 05478

(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 362	Continued From page 3 Per observation on January 30, 2020, the facility failed to ensure corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. Findings include the following: Per observation on January 30, 2020, inspection revealed the corridor closet near the kitchen did not have the required sealing of a penetration.	K 362	**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** Maintenance staff have been re-educated on fire policies. Staff complete monthly environmental audits to include fire safety. **How the corrective actions will be monitored to ensure the deficient practice will not recur?** Maintenance staff will review findings with NHA and team during environmental meetings, monthly. **The dates corrective action will be completed.** Corrective action was completed on 01/30/2020.	
K 511 SS=B	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Per observation on January 30, 2020, the facility failed to ensure that equipment using gas or related to gas piping complies with NFPA 54, National Fuel Gas Code, and that electrical wiring and equipment complies with NFPA 70, National Electric Code. Findings include the following: Per observation on January 30, 2020, inspection revealed that a receptacle was damaged in the dining room (the ground portion was slightly cracked).		**K511** **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** Maintenance staff have been re-educated on policies regarding electrical safety. Electrical safety audits are to be completed monthly. **How the corrective actions will be monitored to ensure the deficient practice will not recur?** Maintenance staff will reviewed findings of electrical safety audits monthly with NHA for compliance. **The dates corrective action will be completed.** Corrective action was completed on 01/30/2020.	

Attachment: Question 13-FCRC

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475047	MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING	DATE SURVEY COMPLETE: 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY REHAB CENTER LLC	110 FAIRFAX ROAD ST ALBANS, VT

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 293	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Per observation on December 16, 2021, the facility failed to ensure exit and directional signs worked according to regulations. Findings include the following: Per observation on December 16, 2021, and accompanied by the Facilities Maintenance Director, inspection revealed an EXIT sign in the sprinkler control area, outside egress, was not maintained according to 19.2.10.1.
31	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ This REQUIREMENT is not met as evidenced by: Per observation on December 16, 2021, the facility failed to ensure ceiling finishes have a flame spread rating of Class A or Class B. Findings include the following: Per observation on December 16, 2021, and accompanied by the Facilities Maintenance Director, inspection revealed a missing ceiling tile in the storage location on the Four Seasons Wing. Coleen Kohaut, owner/Administrator 1/10/2022

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

The above isolated deficiencies pose no actual harm to the residents

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building
Room 2275
Government Center
Boston, Massachusetts 02203
Northeast Survey & Enforcement Division - Boston

July 21, 2022

Administrator
Franklin County Rehab Center
110 Fairfax Road
St Albans, VT 05478-6299

RE: Enforcement Cycle Start Date: August 19, 2019 through August 20, 2019
Revisits & Other Surveys: July 1, 2022
Substantial Compliance was Achieved Effective: October 31, 2019

Dear Administrator: CMS Certification No. 475047

On July 1, 2022 the State Survey Agency conducted a review/revisit and determined that substantial compliance had been achieved effective October 31, 2019

Termination: RESCINDED
Denial of Payment for New Admissions: RESCINDED

If you have any questions regarding this matter, please contact me at Beverly.Kercz@cms.hhs.gov.

Sincerely,

Beverly A. Kercz -S
Digitally signed by Beverly A. Kercz -S
Date: 2022.07.21 07:34:06 -04'00'

Health Insurance Specialist - Enforcement
LTC Survey & Enforcement Branch, CMS Boston
Northeast Survey & Enforcement Division

cc:
State Survey Agency
State Medicaid Agency
MAC - NGS

Department of Health & Human Services
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2325
Boston, Massachusetts 02203

Division of Survey and Certification / Region I

October 09, 2019

Sent Via E-Mail

Coleen Condon Kohaut, NHA
Owner /Administrator
Franklin County Rehab Center
110 Fairfax Rd.
St. Albans, VT 05478

Re: CMS/Life Safety Code Survey
Provider Number: 47-5047

The attached plan of correction is accepted by the CMS Boston Regional Office for the LSC (Life Safety Code) Comparative Federal Monitoring Survey that was completed at your facility on August 20, 2019.

A re-visit survey may be conducted to confirm that the facility is back in substantial compliance by the State of Vermont.

Should you have any questions, please contact me at Jared.Vega@cms.hhs.gov

Sincerely,

J. Scott Vega, CFI-I
LT, United States Public Health Service
Life Safety Code & Nurse Consultant
Centers for Medicare & Medicaid Services (CMS)

cc: file
State Agency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475047	A. BUILDING **01 - BUILDING 01** B. WING _____	**08/20/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY REHAB CENTER LLC	**110 FAIRFAX ROAD** **ST ALBANS, VT 05478**

(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 A Life Safety Code (LSC) comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on August 19, 2019 and August 20, 2019 following a State Agency survey that was conducted on July 2, 2019. At this comparative Federal Monitoring Survey Franklin County Rehabilitation Center LLC., CCN 475047 was found not in substantial compliance with the requirements for participation in Medicare/Medicaid, 42 CFR, Subpart 483.90(a), Life Safety from fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. The nursing home building is one story with no basement (on slab) with a peaked roof with a wood frame attic (insulated with a sprinkler system and cat walk, mostly accessible). The building is determined to be a wood frame, gypsum, most closely resembling a minimum Type V(000) construction fully sprinkler protected. The building identified as being the nursing home is identified as being built prior to July 5, 2016. The nursing home building construction was stated to be approximately 2004, with no major renovations. The facility was certified after the date of construction for occupancy which is stated to be approximately 2004. The building had ceiling tiles ceilings in the corridors and monolithic ceilings in resident rooms with protection by sprinkler and smoke detection below the ceilings. Resident rooms had wardrobes. The building had an addressable smoke detection system (smoke detectors in the corridors only) tied through a monitoring company	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Coleen Kohaut
TITLE: Administrator/owner
(X6) DATE: 10/1/2019

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

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	475047	A. BUILDING **01 - BUILDING 01** B. WING _____	**08/20/2019**

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K 000	Continued From page 1 with notification to the local volunteer fire department approximately 4 1/2 miles away. Resident rooms had smoke detectors that are not tied into the fire alarm control panel (FACP). The FACP dialer has two lines to transfer signal to the fire department and monitoring company. The nursing home was fully sprinkler protected with a wet and dry (attic) sprinkler system. The sprinkler system is on city water with no fire pump. Emergency backup power to the building was supplied by a (125KW) diesel generator (inside the building, tied into the LSC functions of the building including the fire alarm system, doors, dedicated outlets, emergency lights, call system and boilers). The facility did not admit residents on life support and stated they do not admit bariatric residents beyond the limits of the doors in the facility. The heating ventilation and air conditioning system (HVAC) has supply and return in the corridor and is stated to shut down upon activation of the fire alarm. Resident rooms are provided heat by base board heating limiting the transfer of smoke. One special feature of the building is an outpatient rehabilitation office and waiting area for residents that are discharged but may come back to continue therapy. The facility has a capacity of 64 beds with a census of 58 at the time of the survey. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in	K 293		

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K 293	Continued From page 2 accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on Observation and Interview, the facility failed to properly identify, with a sign on a door, which is neither an exit nor a way of exit access and is located or arranged so it is likely to be mistaken for an exit in accordance with LSC Section 7.10 and 7.10.8.3. This deficient practice could affect one door, and an indeterminable number of residents, staff and visitors. Findings Include: Observation on 08/20/2019 at approximately 8:00am to 10:30am during the facility tour identified a door in the main dinning room leading to the outside which had no proper sign designating the door. The door went to the outside with no hard path to the public way and could be confused as an exit. Interview on 08/20/2019 at the time of observation with the Maintenance Director stated this is not an exit door. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall have a "No Exit" sign in accordance with LSC Section 7.10 and 7.10.8.3. This does not meet the requirement to not have a sign in accordance with LSC Section 7.10 and 7.10.8.3. The finding was verified by the Maintenance Director at the time of observation.	K 293	K293 Adequate signage has been placed on all doors. Signage will be added to any new doors. Maintenance will monitor on an annual basis. Date of Completion: Sept. 16, 2019	

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K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on Record Review and Interview, the facility failed to maintain the documentation of numbers of devices tied to the system such as smoke detectors, door hold open devices, duct detectors and heat detectors in the addressable fire alarm system and had a separate system in resident rooms that was not tied into the fire alarm system and was not inspected in accordance with NFPA 72, 2010 Edition and LSC Section 9.6.1.3, 9.6.1.5 and 9.6.1.7. This deficient practice could affect 58 of 58 residents, and an indeterminable number of staff and visitors. Findings Include: Record Review on 08/19/2019 at approximately 1:30pm to 4:30pm identified the Safetek, Inc., records dated 03/28/2019 and 03/19/2018 did not provide numbers of devices tied into the fire alarm control panel (FACP). The reports indicated the facility was inspected but there was no verification of functional testing of the smoke detectors, door hold open devices, heat detectors, pull stations, audio/visual alarms, or other devices tied into the FACP. Record Review	K 345	K345 Safetec will use NFPA form during scheduled visit for testing of the system on October 4, 2019. This will include numbers of devices tied into the control panel, verification of functional testing of the smoke detectors, door hold open devices, heat detectors, pull stations, audio/visual alarms tied into the panel. Resident room hard wired smoke detector testing will be increased from quarterly test to monthly test by facility maintenance. A log of tests will be completed. Date of Completion: Oct. 4, 2019	

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K 345	Continued From page 4 of the work order invoices dated 03/28/2019 and 03/19/2018 identified 13 pull stations, 43 "FirePrint Photo/Thermal" detectors on both reports with no inventory of audio/visual devices, door hold open device testing. In addition, the documentation on the SafeTek, Inc., work order invoice, dated 03/19/2018 stated, "need to replace horn/strobe in room 409." The SafeTek, Inc., work order invoice, dated 03/28/2019 identified 4 single station smoke detectors that wouldn't go into test mode and stated, "fire doors ok" but there is no record of how many fire doors are tied into the FACP or how often they are tested. Interview on 08/19/2019 at approximately 1:30pm to 4:30pm during the entrance conference and record review with the Maintenance Director stated the fire alarm system was an addressable system with smoke detection in the corridor tied to the FACP. Interview at the same time, with the facility Maintenance Director stated the resident rooms had hard wired smoke detectors, but were not tied to the FACP and these smoke detectors are not tested, they are just replaced every "10 years." Record Review of the Safetek, Inc., records dated 03/28/2019 and 03/19/2018 provided no functional or sensitivity testing for resident room smoke detectors. Interview with the Maintenance Director at the time of record review identified the fire alarm system is an addressable system in the corridor and resident rooms have a system not tied to the FACP and confirmed it was not known how many devices were tied into the fire alarm system. This does not meet the requirement to maintain the fire alarm system in accordance with NFPA 72, 2010 Edition and LSC Section 9.6.1.3, 9.6.1.5 and 9.6.1.7. The finding was verified by the Administrator and	K 345		

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K 345	Continued From page 5 Maintenance Director at the time of Record Review.	K 345		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on Observation, Record Review and Interview, the facility failed to maintain the sprinkler system documentation, sprinkler system sprinklers free from loading, sprinkler escutcheons properly placed to prevent impeding sprinkler operation, the sprinkler box not having the correct storage for replacement sprinklers, and gages not replaced or recalibrated every 5 years in accordance with LSC Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, and NFPA 25, 2011 Edition. The deficient practice could affect 58 of 58 residents, as well as	K 353	K353 TriState Sprinkler has updated their forms to show only what is being inspected during quarterly and annual inspections. Sprinkler heads and pipes were brought back into compliance. Gauges have been replaced. Sprinkler heads are stored and secured in box with at minimum six heads. All escutcheons were checked to ensure they are properly paced and secure. Reviewed quarterly by vendor. Date of Completion: Sept 25, 2019	

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K 353	Continued From page 6 an indeterminable number of staff and visitors. Findings Include: Observation on 08/20/2019 during a facility tour from approximately 8:00am to 10:30am identified multiple examples of sprinklers loaded with debris impeding the sprinkler operation as evidenced by multiple sprinklers loaded with debris including in the nursing area, kitchen and laundry areas. Interview with the Maintenance Director verified the findings at the time of observation. Record review on 08/19/2019 at approximately 1:30pm to 4:30pm of the Tri-State Sprinkler Report of Annual Inspection and Trip Test sprinkler inspection report dated 08/15/2019 documented in both the "Annual Inspection for Dry Pipe Sprinkler Systems" and "Annual Inspection for Wet Pipe Sprinkler Systems" a "Y" for yes to seven questions each including: Sprinklers appear free of leakage Sprinklers appear free of corrosion Sprinklers appear free of foreign material Sprinklers appear free of paint Sprinklers appear free of physical damage Sprinklers appear properly oriented Sprinklers spray patterns appear free of unacceptable obstructions This did not meet the requirement for NFPA 25, 2011 Edition, Section 5.1.1, 5.2.1, 5.2.1.1, 5.2.1.1.1, 5.2.1.1.2 and 5.2.1.1.4. The findings were verified by the Maintenance Director at the times of observation. Observation on 08/20/2019 during a facility tour from approximately 8:00am to 10:30am identified	K 353		

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K 353	Continued From page 7 penetrations of the ceiling tiles with findings of sprinkler escutcheons not properly fitting to the ceiling allowing hot gasses and smoke past the sprinkler into the space above as evidenced by multiple ceiling penetrations. Interview with the Maintenance Director verified the findings at the time of observation. Record review on 08/19/2019 at approximately 1:30pm to 4:30pm of the Tri-State Sprinkler Report of Annual Inspection and Trip Test sprinkler inspection report dated 08/15/2019 documented in both the "Annual Inspection for Dry Pipe Sprinkler Systems" and "Annual Inspection for Wet Pipe Sprinkler Systems" a "Y" for yes to seven questions each including: Sprinklers appear free of leakage Sprinklers appear free of corrosion Sprinklers appear free of foreign material Sprinklers appear free of paint Sprinklers appear free of physical damage Sprinklers appear properly oriented Sprinklers spray patterns appear free of unacceptable obstructions Any inspection of sprinklers would include checking the escutcheons and penetrations. This did not meet the requirement for NFPA 25, 2011 Edition, Section 5.1.1, 5.2.1.1, 5.2.1.2 and 5.2.2. The findings were verified by the Maintenance Director at the times of observation. Observation on 08/20/2019 during a facility tour from approximately 8:00am to 10:30am identified the facility sprinkler box did not have the spare sprinklers for each type used in the facility and not all sprinklers were securely stored in the sprinkler box leaving them prone to damage. In	K 353		

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K 353	Continued From page 8 addition, there was a very limited number of sprinklers, which was not identified in the annual sprinkler record review. Interview with the Maintenance Director verified the findings at the time of observation. Record review on 08/19/2019 at approximately 1:30pm to 4:30pm of the Tri-State Sprinkler Report of Annual Inspection and Trip Test sprinkler inspection report dated 08/15/2019 documented in both the "Annual Inspection for Dry Pipe Sprinkler Systems" and "Annual Inspection for Wet Pipe Sprinkler Systems" a "Y" for yes to three questions each including: Spare sprinklers are of proper number (at least 6), type, and temperature rating Spare sprinklers stored where temperature maximum is 100(Degrees)F Wrench available for each type of sprinkler This did not meet the requirement for NFPA 25, 2011 Edition, Section 5.2.1.4, 5.4 and 5.4.1.5. The findings were verified by the Maintenance Director at the time of observation. Observation on 08/20/2019 during a facility tour from approximately 8:00am to 10:30am identified that the facility had four gauge on the sprinkler system dated for the year 2010 and no documentation that the gauges were recalibrated or replaced every 5 years. Record review on 08/19/2019 at approximately 1:30pm to 4:30pm of the Tri-State Sprinkler Report of Annual Inspection and Trip Test sprinkler inspection report dated 08/15/2019 documented the supply water gauge reading before flow (static) as "60 psi" and gauge reading during stable flow (residual) as "50psi" however did not any check of	K 353		

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K 353	Continued From page 9 the sprinkler gages for recalibration and/or replacement (required to be replaced/recalibrated every 5 years). This did not meet the requirement for NFPA 25, 2011 edition, Section 5.1, 5.2, and 5.3.2. The findings were verified by the Maintenance Director at the times of observation. Record review on 08/19/2019 at approximately 1:30pm to 4:30pm identified the "Tri-State Sprinkler Report of Annual Inspection and Trip Test sprinkler inspection report," sprinkler system inspection reports identified sprinkler reports dated 08/15/2019 (most recent, five days prior to the survey), 05/09/2019 (annual), 02/25/2019 (annual) and 11/12/2018 (annual). Of the records reviewed, all of the records were identified as annual inspections.	K 353		
K 361 SS=D	Corridors - Areas Open to Corridor CFR(s): NFPA 101 Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 This REQUIREMENT is not met as evidenced by: Based on Observation and Interview, the facility failed to provide separation for treatment area from the corridor in accordance with LSC Section 19.3.6.1. This deficient practice could affect one smoke zone, as well as an indeterminable number of residents, staff and visitors.	K 361	K361 A lockout system will be placed on the stove in the rehab wing. This will prevent unauthorized users from being able to turn on and use the stove. Franklin County Rehab Center is requesting a waiver to extend the date of completion due to equipment ordering and installation time frames to ensure compliance with this regulation. Date of Completion: Nov. 22, 2019	

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K 361	Continued From page 10 Findings Include: Observation on 08/20/2019 at approximately 8:00am to 10:30am during the facility tour identified the corridor in the physical therapy wing opened up to a large space housing the physical therapy in the center of the open area (separated by walls and curtains) with the corridor space around the physical therapy section. Observation of the area outside of the physical therapy section was a small area open to the corridor and separated from the partitions of the physical therapy area that contained a kitchen area. Observation of the kitchen area identified a standard cooking stove with no safety lock out, cabinets, sink and equipment used for occupational therapy services that is open to the corridor. Interview at the time of observation with the Maintenance Director confirmed the area is open to the corridor and is utilized for occupational therapy. This did not meet the intent of LSC Section 19.3.6.1. The findings were verified by the Maintenance Director at the times of observation.	K 361		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible	K 363	K363 Adjustments made to doors that didn't close correctly. Doors will be checked on quarterly rounds completed by maintenance. Door wedges have been removed; staff has been educated on use. Date of Completion: October 1, 2019	

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K 363	Continued From page 11 materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on Observation and Interview, the facility failed to ensure doors protecting corridor smoke partitions (resident room doors) are not prevented from closing by use of door wedges (an unapproved device) to hold open corridor doors in accordance with LSC Section 19.3.6.3.1. This deficient practice could affect two smoke zones, as well as an indeterminable number of residents, staff and visitors.	K 363		

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K 363	Continued From page 12 Findings Include: Observation on 08/20/2019 at approximately 8:00am to 10:30am during the facility tour identified the corridor doors to resident room 211 and resident room 410 had wooden door wedges at the foot of the doors holding the doors open. The door was being held in an open position and could not automatically be closed in case of fire without having to spot the door wedge and remove it to close the door. Observation of resident room 211, identified that when the door wedge was removed, the door closed on its own. Interview at the time of observation with the Maintenance Director confirmed the door was not closing to latch and would not resist the passage of smoke due to unapproved hold open devices preventing operation of the doors. Interview at the time of observation with the Maintenance Director identified the doors were not properly aligned to stay open and automatically closed upon removing the wedge at resident room 211. Observation identified other rooms may have also had unapproved hold open devices. This did not meet the intent of LSC Section 19.3.6.3.1. The findings were verified by the Maintenance Director at the times of observation.	K 363		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct	K 372	K372 All penetration areas have been checked and fixed with proper fire caulk securing the area. Maintenance will check areas post any new construction for proper fire caulking placement. Date of Completion: Sept. 25, 2019	

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	475047	A. BUILDING **01 - BUILDING 01** B. WING _____	**08/20/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY REHAB CENTER LLC	**110 FAIRFAX ROAD** **ST ALBANS, VT 05478**

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K 372	Continued From page 13 penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on Observation and Interview, the facility failed to provide a smoke barrier with a 1/2 hour fire resistance rating in accordance with LSC Section 8.5.3 and Section 19.3.7.3. This deficient practice could affect two sampled facility identified smoke barriers, as well as an indeterminable number of residents, staff and visitors. Findings Include: Observation on 08/20/2019 at approximately 8:00am to 10:30am during the facility tour identified the facility specified smoke barrier walls near the main dining room and on the opposite side near the activity room had a penetration by a cable that was not properly fire stopped. Observation of the penetrations identified cables went through the smoke barrier wall, with either no through penetration system or the penetration with no known fire caulking properties. Observations were verified by the Maintenance Director as a penetration providing no through penetration system to ensure the integrity of a smoke barrier. Interview on 08/19/2019 at approximately 1:30pm to 4:30pm with the Maintenance Director at the time of record review identified the facility utilizes a "3M red fire caulk" for all penetrations. Interview with the Maintenance Director at the time of observation	K 372		

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K 372	Continued From page 14 stated that the identified wall was a smoke barrier wall which was confirmed by the rated doors at the smoke barrier and facility floor plans showing cross corridor separation. This did not meet the requirement of LSC Section 8.5.3 and Section 19.3.7.3. The findings were verified by the Maintenance Director at the times of observation.	K 372		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on Record Review and Interview, the facility failed to conduct fire drills at varied times in accordance with LSC Sections 19.7.1.4 through 19.7.1.7. This deficient practice could affect 58 of 58 residents, as well as an indeterminable number of staff and visitors. Findings Include: Record review on 08/19/2019 at approximately 1:30pm to 4:30pm identified fire drill records from all three shifts had documented fire drills not	K 712	K712 Fire drills will be completed on each shift on a quarterly basis, with one shift being tested per month. The schedule will be set to not follow any pattern of date or time. Date of Completion: Oct 1, 2019	

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K 712	Continued From page 15 conducted at varied times. Interview on 08/19/2019 at approximately 2:00pm at the facility entrance conference with the facility administration staff stated that the facility has three shifts and stated the shifts are 7:30am to 3:30pm, 3:30pm to 11:30pm and 11:30pm to 7:30am. Record review on 08/19/2019 at approximately 1:30pm to 4:30pm identified fire drills for the 7:30am to 3:30pm shift dated 06/30/2018 was conducted at 1:15pm, 10/20/2018 and 03/06/2019 both conducted at 1:45pm and dated 06/20/2019 was conducted at 1:10pm (four of five fire drills conducted between 1:15pm and 1:45pm with two of five conducted at the same time). Record review on 08/19/2019 at approximately 1:30pm to 4:30pm identified fire drills for the 3:30pm to 11:30pm shift dated 09/14/2018 was conducted at 7:15pm, dated 12/11/2018 and 02/22/2019 both conducted at 7:45pm and dated 04/23/2019 was conducted at 8:05pm (four of four fire drills conducted between 7:15pm and 8:05pm with two of four conducted at the same time). Record review on 08/19/2019 at approximately 1:30pm to 4:30pm identified fire drills for the 11:30pm to 7:30am shift dated 07/21/2018 was conducted at 5:30am and 01/14/2019 at 5:15am (within 15 minutes of each other) and drills on 11/30/2018 was conducted at 1:50am and 06/22/2019 was conducted at 1:00am which may appear more as a pattern than random. The documentation for fire drills identified as not being conducted at varied times is not in accordance with LSC Sections 19.7.1.4 through	K 712		

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K 712	Continued From page 16 19.7.1.7. The findings were verified with the Maintenance Director at the time of Record Review.	K 712		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new	K 918	K918 Maintenance personnel will document weekly visual inspections of the battery, hoses and clamps, and levels of all fluids. Specific gravity readings or electrolyte levels of the battery will be checked and recorded monthly. Transfer times and load testing will also be checked and recorded on a monthly basis ensuring that it is meeting the minimum 30% name plate KW rating. Date of Completion: October 31, 2019	

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K 918	Continued From page 17 installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on Interview and Record Review, the facility failed to properly document generator required weekly testing such as battery supply, fuel, lubrication systems, cooling systems, exhaust systems, etc., in accordance with NFPA 99, 2012 Edition, Section 6.4.1.2., NFPA 70, 2011 Edition, Article 700, and NFPA 110, 2010 Edition, Section 8.3.7. This deficient practice could affect 58 of 58 residents, as well as an indeterminable number of staff and visitors. Findings Include: Record review on 08/19/2019 at approximately 1:30pm to 4:30pm identified the facility had a diesel generator (125KW) inside the facility with no records documenting routine maintenance of weekly water level checks and monthly specific gravity checks or other weekly monitoring as required for the battery power for the starting system. Interview at the time of record review with the Maintenance Director verified the facility had a generator tied to LSC functions in the facility (fire alarm panel, doors, emergency lighting, emergency outlets, call system and the boiler). Record review of the facility generator logs identified the generator is run however no monthly measures of the load to the name plate rating are taken. Based on interview at the time of record review, the facility cannot verify if the generator is running at any specific load monthly. In addition, weekly generator information such as battery specific gravity readings or electrolyte levels, transfer times, exhaust, cooling system	K 918		

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K 918	Continued From page 18 checks, and others are not documented. Interview with the Maintenance Director and record review identified that the facility documentation for the generator did not include specific gravity on a monthly basis or electrolyte levels on a weekly basis. Record review indicated no transfer times, no AMP/KW/KVA readings with no load monthly, just a record for full load on a monthly basis. Without proper maintenance, the generator functioning is unknown as it may be running at a significantly less load then required and not getting to minimum requirements to maintain the generator for times of need. This did not meet NFPA 99, 2012 Edition, Section 6.4.1.2., NFPA 70, 2011 Edition, Article 700, and NFPA 110, 2010 Edition, Section 8.3.7. The finding was verified by the Maintenance Director at the time of observation.	K 918		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL	K 920	K920 Temporary construction lighting that was left not hooked up in the attic was removed during inspection. Anytime work is completed in the facility maintenance will check for any remaining cords. Date of Completion: August 20, 2019	

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K 920	Continued From page 19 standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on Observation and Interview, the facility failed to protect electrical wiring from becoming potential hazards as evidenced by one temporary construction lighting cord not removed following construction, in accordance with NFPA 70, 2011 Edition Article 400.8, Article 590.2(B), NFPA 99, 2012 Edition, Section 10.2.4 and LSC Section 9.1.2. The deficient practice could affect the attic, as well as an indeterminable number of residents, staff and visitors. Findings Include: Observation on 08/20/2019 at approximately 8:00am to 10:30am during the facility tour identified a temporary construction lighting remained in the attic with no construction or work being completed at the time of survey. Interview with the Maintenance Director at the time of observation confirmed the temporary construction lighting/wiring was present and concurred that is should not be in the attic space. The findings did not meet requirements to protect electrical wiring from becoming potential hazards, in accordance with NFPA 70, 2011 Edition Article 400.8, Article 590.2(B), NFPA 99, 2012 Edition, Section 10.2.4 and LSC Section 9.1.2.	K 920		

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K 920	Continued From page 20 The finding was verified by the Maintenance Director at the time of observation.	K 920		
K 927 SS=D	Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101 Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99), 11.5.2.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on Observation and Interview the facility failed to provide a designated, separated and protected area of the building for properly transfilling liquid oxygen containers in accordance with LSC Section 19.3.2.4 and NPFA 99, 2012 Edition Sections 11.5.2.2, 11.5.2.3 and 11.7. This deficient practice could affect one oxygen storage/transfilling area, as well as an indeterminable number of residents, staff and visitors. Findings Include: Observation on 08/20/2019 from approximately 8:00am to 10:30am during the facility tour identified the identified room used for storage of liquid oxygen and transfilling of liquid oxygen housed three large oxygen containers leaving no	K 927	K927 Area has been organized and will only house 5 liquid oxygen tanks at a time. Floor has been marked to indicate area for staff to fill and area for tank placement. Signage has been added to ensure staff is educated on the process, and to ensure that the door remains closed at all times. Date of Completion: Sept. 30, 2019	

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K 927	Continued From page 21 room for transfilling of oxygen in the room with the door closed to protect and separate the transfilling process from the facility. Interview with the Maintenance Director at the time of observation confirmed the room was used for transfilling oxygen and that there was no way to transfill the oxygen in the room with the door closed due to there being no room inside the room for safe transfilling of oxygen containers. The facility failed to provide a designated, separated and protected area of the building for properly transfilling liquid oxygen containers in accordance with LSC Section 19.3.2.4 and NPFA 99, 2012 Edition Sections 11.5.2.2, 11.5.2.3 and 11.7. The finding was verified by the Maintenance Director at the time of observation.	K 927		
K 930 SS=D	Gas Equipment - Liquid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on Observation and Interview the facility failed to properly protect a liquid oxygen container in accordance with LSC Section 19.3.2.4 and NPFA 99, 2012 Edition Sections 11.7 (11.7.3.2). This deficient practice could affect one oxygen container, as well as an indeterminable number of residents, staff and visitors. Findings Include:	K 930	K930 Staff has been educated on the importance of oxygen handling and storage. Date of Completion: October 1, 2019	

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K 930	Continued From page 22 Observation on 08/20/2019 from approximately 8:00am to 10:30am during the facility tour identified one freestanding liquid oxygen container stored on the floor in the facility corridor outside the nursing station without being properly safeguarded from foot traffic or hazards. Interview with the Maintenance Director at the time of observation confirmed the portable liquid oxygen container was left unattended. The facility failed to properly protect a liquid oxygen container in accordance with LSC Section 19.3.2.4 and NPFA 99, 2012 Edition Sections 11.7 (11.7.3.2). The finding was verified by the Maintenance Director at the time of observation.	K 930		

Attachment: Question 14

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Room 2275
Government Center
Boston, MA 02203

CENTERS FOR MEDICARE & MEDICAID SERVICES

Northeast Division of Survey & Certification

January 22, 2020
Via E-Mail Only

April Furlow
Administrator
The Villa Rehab
7 Forest Hill Drive
St. Albans, VT 05478-1615

RE: Enforcement Cycle Start Date: November 18, 2019 through November 20, 2019
Enforcement Remedies - Pending: Mandatory Denial of Payment for New Admissions effective February 20, 2020; Mandatory Termination effective May 20, 2020.
Civil Money Penalty(CMP) - IMPOSED: Effective November 20, 2019, CMS is imposing a Per Instance Civil Money Penalty (CMP) of $12,250.00, based on the non-compliance cited at Federal Tags: F0689 -- S/S: G -- § 483.25(d)(1)(2) -- Free Of Accident Hazards/Supervision/Devices and F0658 -- S/S: G -- § 483.21(b)(3)(i) -- Services Provided Meet Professional Standards. The total assessed CMP as of January 22, 2020 is $12,250.00.
Nurse Aide Training And Competency Evaluation Program (NATCEP) Prohibition - IMPOSED: November 20, 2019 through November 19, 2021.

Dear Administrator: CMS Certification Number: 475055

On November 18, 2019 through November 20, 2019, a recertification and complaint survey was completed at your facility by the Vermont Department of Health, Division of Licensing & Protection (State Survey Agency). This survey was conducted to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. This survey found deficiencies that require significant correction be made in order for your facility to continue to participate in the Medicare and Medicaid programs.

Your Enforcement Cycle began with the November 18, 2019 through November 20, 2019 survey. All surveys conducted after November 20, 2019, will become a part of this Enforcement Cycle. The enforcement cycle will not end until substantial compliance is achieved for all deficiencies from all surveys within an enforcement cycle or termination occurs. Facilities are expected to achieve and maintain continuous substantial compliance.

The State Survey Agency may recommend to the Centers for Medicare & Medicaid Services (CMS) Regional Office and to the State Medicaid Agency that certain remedies be imposed, unless substantial compliance is achieved at your first revisit. These would be in addition to the statutory three month Denial of Payment for New Admissions and six month Termination requirements. The statutory remedies will go into effect per the effective dates below without additional notification from this office. CMS may exercise its authority to alter the remedies imposed. All regulatory references may be found

writing (e.g., by U.S. mail or via e-mail to Beverly.Kercz@cms.hhs.gov).

Should you waive your appeal rights and achieve substantial compliance, the CMP will be due for payment within 15 days of CMS notifying you that the waiver of appeal rights has been approved, 42 C.F.R. § 488.422. Should you not waive your appeal rights and not file an appeal, payment is due 15 days after the time period for requesting a hearing has expired if the facility has achieved substantial compliance, or 15 days after the effective date of termination, whichever is earlier, 42 C.F.R. § 488.442. CMS will send instructions indicating how, where and when to send payment.

If you fail to pay the CMP, CMS may deduct the CMP amount from any sums owed you by Medicare and/or Medicaid. Additionally, if payment is not received on time, interest will accrue at the 10.625%.

FACTORS USED IN DETERMINING THE AMOUNT OF YOUR CMP AND REQUIREMENTS FOR FINANCIAL HARDSHIP REQUESTS

In determining the amount of the CMP that we are imposing, we have considered your facility's history of noncompliance, including repeated deficiencies; its financial condition; the factors specified in the Federal requirement at 42 CFR § 488.404; and the facility's degree of culpability, including, but not limited to, neglect, indifference, or disregard for resident care, comfort or safety. (Under 42 CFR § 488.438(f)(4), the absence of culpability is not a mitigating circumstance in reducing the amount of the penalty.)

If you believe that you have documented evidence that should be considered in establishing the amount of the CMP, the following documents should be submitted to our office within fifteen (15) days of your receipt of this notice:

1. A letter outlining the specific financial hardship;
2. Current balance sheet;
3. Current income statement;
4. Cash flow statement;
5. Most recent full year financial statements prepared by an independent accounting firm. Be certain to include footnotes;
6. Most recent full year financial statements of the home office and/or related entities;
7. Disclosure of expenses and amounts paid/accrued to the home office and/or other related entities;
8. Copy of tax returns for the preceding two years;
9. Documentation of any/all financing arrangements including mortgages, long term debt and lines of credit;
10. Copy of a letter from the Bank denying the nursing home a loan;
11. Provide an organizational chart with an explanation/description concerning the related entities; and,
12. Signed copy of an attestation statement by the Administrator, CFO, CEO, and owner (The attestation statement form will be sent to you upon submission of your request for a financial hardship determination.)

As explained above, should you decide to waive your appeal rights within 60 calendar days of your receipt of this notice, CMS will reduce your CMP by thirty-five percent (35%). Your waiver of appeal rights must be submitted in writing (e.g., by U.S. Mail or via e-mail to Beverly.Kercz@cms.hhs.gov).

NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAM (NATCEP)

- Tax Identification Number (TIN) or Employer Identification Number (EIN).
- A copy of CMS Regional Office (RO) decision.

An appeal/request for hearing must be filed no later than sixty (60) calendar days from the date of your receipt of this letter. Requesting an appeal will not stop the termination action.

You must file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov.

To file a new appeal using DAB E-File, you first need to register a new account by:
(1) clicking Register on the DAB E-File home page;
(2) entering the information requested on the "Register New Account" form; and
(3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf. The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he is a party or authorized representative.

Once registered, you may file your appeal by:
(1) clicking the **File New Appeal** link on the Manage Existing Appeals screen;
(2) then clicking **Civil Remedies Division** on the File New Appeal screen; and,
(3) entering and uploading the requested information and documents on the "File New Appeal- Civil Remedies Division" form.

Your request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including the finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request.

At a minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals. If you have any questions about the CRD E-File process, please contact 608-301-2787 between the hours of 8:00AM and 4:00 PM. You are **required** to e-file your appeal request.

A courtesy copy of the hearing request should be sent to Beverly.Kercz@cms.hhs.gov.

REMINDER

Our letter sets forth specific timeframes to which your facility must comply:

1. A request for IIDR must be made within 10 calendar days of your receipt of this notice per the