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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1Y7T

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00780

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E507**
2.STATE VENDOR OR MEDICAID NO.
(L2) **904343800**

3. NAME AND ADDRESS OF FACILITY
(L3) **SOUTHSIDE CARE CENTER**
(L4) **2644 ALDRICH AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55408**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/12/2012** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **10** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **17** (L18)

13.Total Certified Beds **17** (L17)

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

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

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

* Code: **A 4,8** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
		17		
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Sarah Grebenc, HPR Social Work Specialist 03/23/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 04/23/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/26/1978
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS
Posted 4/24/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/16/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

CCN# 24E507

A standard survey was completed at this facility on December 30, 2011. The most serious deficiencies were found at a S/S level of F.

A health post certification revisit (PCR) was completed on February 21, 2012 and a LSC PCR was completed on February 3, 2012. Two health deficiencies were found uncorrected at a S/S level of D.

As a result, we imposed state monitoring effective March 5, 2012.

In addition, we recommended the following to CMS and CMS concurred:

- Mandatory DOPNA effective March 30, 2012

The facility would also be subject to a loss of NATCEP to be effective March 30, 2012

A second health PCR was completed on March 12, 2012 and the facility was found in substantial compliance, effective March 12, 2012. As a result, we discontinued state monitoring, effective March 12, 2012. We also recommended the following action to the CMS RO and CMS RO concurred:

- Mandatory DOPNA effective March 30, 2012, be rescinded.

The facility would not be subject to the loss of NATECP is DOPNA is rescinded.

The facility's request for waiver of the following requirements has been approved:

- F354 - 42 CFR 483.30(b) - Seven day registered nurse coverage
- F458 - 42 CFR 483.70(d)(1)(ii) - Resident room size requirements

See attached health CMS-2567B dated March 12, 2012.

Protecting, Maintaining and Improving the Health of Minnesotans

CCN# 24E507

April 23, 2012

Mr. Mark Anderson, Administrator
Southside Care Center
2644 Aldrich Avenue South
Minneapolis, Minnesota 55408

Dear Mr. Anderson:

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

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

Effective March 12, 2012 the above facility is certified for:

17 Nursing Facility II Beds

Your request for waiver of F354 and F458 has been approved based on the submitted documentation.

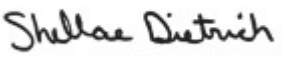
If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Program.

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

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

Please contact me if you have any questions.

Sincerely,



Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 23, 2012

Mr. Mark Anderson, Administrator
Southside Care Center
2644 Aldrich Avenue South
Minneapolis, Minnesota 55408

RE: Project Number SE507021

Dear Mr. Anderson:

On February 29, 2012, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective March 5, 2012. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 30, 2012. (42 CFR 488.417 (b))

Also, we notified you in our letter of February 29, 2012, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 30, 2012.

This was based on the deficiencies cited by this Department for a standard survey completed on December 30, 2011, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on February 21, 2012. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On March 12, 2012, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on February 21, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 12, 2012. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on February 21, 2012, as of March 12, 2012. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective March 12, 2012.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of February 21, 2012. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 30, 2012, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective March 30, 2012, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective March 30, 2012, is to be rescinded.

In our letter of February 29, 2012, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 30, 2012, due to denial of payment for new admissions. Since your facility attained substantial compliance on March 12, 2012, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Your request for continuing waivers involving the deficiencies cited under F354 and F458 at the time of the December 30, 2011 standard survey has been approved.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Gloria Derfus

Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3792 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File E507r212.rtf

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E507	A. Building B. Wing	3/12/2012

Name of Facility	Street Address, City, State, Zip Code
SOUTHSIDE CARE CENTER	2644 ALDRICH AVENUE SOUTH MINNEAPOLIS, MN 55408

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	**03/12/2012**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	**03/12/2012**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** GD/sd	**Date:** 03/23/12	**Signature of Surveyor:** 28589	**Date:** 03/12/12
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 12/30/2011		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00780	A. Building B. Wing	3/12/2012

Name of Facility	Street Address, City, State, Zip Code
SOUTHSIDE CARE CENTER	2644 ALDRICH AVENUE SOUTH MINNEAPOLIS, MN 55408

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **30670** Reg. # **MN Rule 4655.4000 Subp.** LSC	**03/12/2012**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/sd	03/23/12	28589	03/12/12
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 12/30/2011

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1Y7T

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00780

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E507**
2.STATE VENDOR OR MEDICAID NO.
(L2) **904343800**

3. NAME AND ADDRESS OF FACILITY
(L3) **SOUTHSIDE CARE CENTER**
(L4) **2644 ALDRICH AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55408**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/21/2012** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **10** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **17** (L18)

13.Total Certified Beds **17** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** 4,8 (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
		17		
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Sarah Grebenc, HPR-Social Work Specialist 02/29/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 03/27/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/26/1978
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS
Posted 4/6/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/16/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

CCN# 24E507

A standard survey was completed at this facility on December 30, 2011. The most serious deficiencies were found at a S/S level of F.

A health post certification revisit (PCR) was completed on February 21, 2012 and a LSC PCR was completed on February 3, 2012. Two health deficiencies were found uncorrected at a S/S level of D.

As a result, we imposed state monitoring effective March 5, 2012.

In addition, we recommended the following to CMS and CMS concurred:

- Mandatory DOPNA effective 03/30/12

The facility would also be subject to a loss of NATCEP to be effective 03/30/12

The facility's request for waiver of the following requirements has been approved:

- F354 - 42 CFR 483.30(b) - Seven day registered nurse coverage
- F458 - 42 CFR 483.70(d)(1)(ii) - Resident room size requirements

See attached health CMS-2567 and 2567B dated February 21, 2012 and LSC 2567B dated February 3, 2012.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 5073

February 29, 2012

Mr. Mark Anderson, Administrator
Southside Care Center
2644 Aldrich Avenue South
Minneapolis, Minnesota 55408

RE: Project Number SE507021

Dear Mr. Anderson:

On January 20, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 30, 2011. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On February 21, 2012, the Minnesota Department of Health and on February 3, 2012, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 30, 2011. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 9, 2012. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on December 30, 2011. The deficiencies not corrected are as follows:

F0272 -- S/S: D -- 483.20(b)(1) -- Comprehensive Assessments

F0325 -- S/S: D -- 483.25(i) -- Maintain Nutrition Status Unless Unavoidable

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective March 5, 2012. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective March 30, 2012. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective March 30, 2012. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 30, 2012. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Southside Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective March 30, 2012. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Oliver Potts, Chief

330 Independence Avenue, SE
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

DEPARTMENT CONTACT

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

Gloria Derfus
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792

Fax: (651) 201-3790

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

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

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 30, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Gloria Derfus

Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3792 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File E507r112.rtf

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E507	A. Building B. Wing	2/21/2012

Name of Facility	Street Address, City, State, Zip Code
SOUTHSIDE CARE CENTER	2644 ALDRICH AVENUE SOUTH MINNEAPOLIS, MN 55408

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **01/22/2012**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **01/29/2012**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **01/29/2012**
ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **01/25/2012**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **02/03/2012**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **02/01/2012**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **02/01/2012**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **02/02/2012**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/sd	02/29/12	28589	02/21/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 12/30/2011

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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
	24E507	A. BUILDING _____ B. WING _____	R 02/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHSIDE CARE CENTER	2644 ALDRICH AVENUE SOUTH MINNEAPOLIS, MN 55408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		
{F 272} SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F272	The Nutrition Assessment form has been revised to include-"Ideal Weight, Calories & Protein Intake" needs calculations. Registered Dietician has completed the assessment for R 18 and other at risk residents. R 18 was seen by her physician and an Endocrinologist on 3/6/12 and a medication change for her diabetes was prescribed. The Weight Loss policy was reviewed by the Program Director and Registered Dietician on 2/29/12. Food intake monitoring & logs will continue until desired, calculated weight is reached. DON to monitor weekly weights and food intake logs for compliance.	3/9/12

RECEIVED
MAR 07 2012
COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 3/6/12

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
	24E507	A. BUILDING _____ B. WING _____	R 02/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHSIDE CARE CENTER	2644 ALDRICH AVENUE SOUTH MINNEAPOLIS, MN 55408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 272}	Continued From page 1	{F 272}		

This REQUIREMENT is not met as evidenced by:
Based on document review and interview, the facility failed to provide a comprehensive assessment for 1 of 3 residents (R18) reviewed in the sample that had identified weight loss.

Findings include:

R18 lacked a comprehensive nutritional assessment.

On 2/10/12, R18 was referred to her physician to be evaluated for weight loss. At the time of the referral, R18 had diagnoses of poorly controlled diabetes, bipolar disorder, schizophrenia and high blood pressure. According to the referral, R18 had lost 11 pounds from October to December of 2011. The weight loss represented a 6.8% loss over three months.

A nutritional assessment was completed on 1/21/12, and 2/14/12 by the facility dietitian. The assessment summary dated 1/21/12, indicated R18 continued to lose weight, refuse meals, drink fluids excessively and steal others' food and drink. The recommendation was to initiate a supplement suitable for a person with diabetes. The assessment dated 2/14/12, indicated R18 refused the supplement that was started in January 2012 and liked to drink chocolate soy milk instead. The dietitian encouraged R18 to continue with the supplement. R18 had stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	R 02/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHSIDE CARE CENTER	2644 ALDRICH AVENUE SOUTH MINNEAPOLIS, MN 55408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 272}	Continued From page 2 she would drink the supplement only if she could continue to have her chocolate soy drink as well. Both assessments lacked a determination of R18's protein, calorie and fluid needs, an evaluation of food and fluid intake, and an evaluation of R18's poorly controlled diabetes. During an interview with the program manager at 10:00 a.m. on 2/21/12, he stated he believed R18 may have lost weight related to her poorly controlled diabetes. He explained R18 was non-compliant with getting blood sugar checks, and would drink fluids continually which included orange juice. He also stated R18 had a good appetite and would eat second and sometime third helpings. Review of the appetite intake records revealed R18 was eating 75-100% or more of her lunch and supper meals for the month of February 2012. The facility dietitian stated during an interview at 2:30 p.m. on 2/21/12, she had not assessed calorie and protein needs for any of the residents. She explained the calculation was not included on the facility assessment form. The dietitian was aware that R18 had uncontrolled diabetes and believed R18 was not eating well. The dietitian was not aware of R18's intake of meals was recorded and therefore had not evaluated her documented intake. The Significant Weight Loss policy, undated, directed staff to alert the facility dietitian. Per policy, the dietitian was to evaluate the resident's calorie and protein needs, review the appetite intake records and initiate a three day or longer intake record if needed. According to facility policy a significant weight loss was defined as:	{F 272}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	R 02/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHSIDE CARE CENTER	2644 ALDRICH AVENUE SOUTH MINNEAPOLIS, MN 55408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 272}	Continued From page 3 5% over 30 days, 7.5% over 90 days or 10% over 180 days, and severe weight loss would be any loss greater than the above mentioned percentages. Therefore, R18 had experienced a severe weight loss as defined by the policy.	{F 272}		
{F 325} SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on Interview and record review, the facility failed to provided neccesary care and services for 1 of 3 residents (R18) reviewed in the sample that had identified weight loss. Findings include: R18 lacked a comprehensive nutritional assessment for her weight loss. On 2/10/12, R18 was referred to her physician to be evaluated for weight loss. At the time of the referral, R18 had diagnoses of poorly controlled diabetes, bipolar disorder, schizophrenia and high blood pressure. According to the referral, R18	F325	The Nutrition Assessment form has been revised to include-"Ideal Weight, Calories & Protein Intake" needs calculations. Registered Dietician has completed the assessment for R 18 and other at risk residents. R 18 was seen by her physician and an Endocrinologist on 3/6/12 and a medication change for her diabetes was prescribed. The Weight Loss policy was reviewed by the Program Director and Registered Dietician on 2/29/12. Food intake monitoring & logs will continue until desired weight is reached. DON to monitor weekly food intake logs and weights for compliance.	3/9/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	R 02/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHSIDE CARE CENTER	2644 ALDRICH AVENUE SOUTH MINNEAPOLIS, MN 55408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 325}	Continued From page 4 had lost 11 pounds from October to December of 2011. The weight loss represented a 6.8% loss over three months. The care plan for R18 dated 10/18/11, indicated a weight loss problem, a problem of drinking too much orange juice, and a problem of high blood glucose. The interventions included providing R18 with additional calories and protein through the provision of a supplement of eight ounces twice daily, even though R18's calorie, protein and intake records were not assessed. A nutritional assessment was completed on 1/21/12, and 2/14/12 by the facility dietitian. The assessment summary dated 1/21/12, indicated R18 continued to lose weight, refuse meals, drink fluids excessively and steal others' food and drink. The recommendation was to initiate a supplement suitable for a person with diabetes. The assessment dated 2/14/12, indicated R18 refused the supplement that was started in January 2012 and liked to drink chocolate soy milk instead. The dietitian encouraged R18 to continue with the supplement. R18 had stated she would drink the supplement only if she could continue to have her chocolate soy drink as well. Both assessments lacked a determination of R18's protein, calorie and fluid needs, an evaluation of food and fluid intake, and an evaluation of R18's poorly controlled diabetes. During an interview with the program manager at 10:00 a.m. on 2/21/12, he stated he believed R18 may have lost weight related to her poorly controlled diabetes. He explained R18 was non-compliant with getting blood sugar checks, and would drink fluids continually which included	{F 325}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	R 02/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHSIDE CARE CENTER	2644 ALDRICH AVENUE SOUTH MINNEAPOLIS, MN 55408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 325}	Continued From page 5 orange juice. He also stated R18 had a good appetite and would eat second and sometime third helpings. Review of the appetite intake records revealed R18 was eating 75-100% or more of her lunch and supper meals for the month of February 2012. The facility dietitian stated during an interview at 2:30 p.m. on 2/21/12, she had not assessed calorie and protein needs for any of the residents. She explained the calculation was not included on the facility assessment form. The dietitian was aware that R18 had uncontrolled diabetes and believed R18 was not eating well. The dietitian was not aware of R18's intake of meals was recorded and therefore had not evaluated her documented intake. The Significant Weight Loss policy, undated, directed staff to alert the facility dietitian. Per policy, the dietitian was to evaluate the resident's calorie and protein needs, review the appetite intake records and initiate a three day or longer intake record if needed. According to facility policy a significant weight loss was defined as: 5% over 30 days, 7.5% over 90 days or 10% over 180 days, and severe weight loss would be any loss greater than the above mentioned percentages. Therefore, R18 had experienced a severe weight loss as defined by the policy.	{F 325}		
{F 354} SS=C	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.	F354	Waiting for approval on previous January 2012"Waiver Request". Administrator to monitor.	3/9/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	R 02/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHSIDE CARE CENTER	2644 ALDRICH AVENUE SOUTH MINNEAPOLIS, MN 55408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 354}	Continued From page 6 Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by:	{F 354}		
{F 458} SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by:	F 458	Waiting for approval on previous January 2012"Waiver Request". Administrator to monitor.	3/9/12

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E507	A. Building B. Wing **01 - MAIN BUILDING 01**	2/3/2012

Name of Facility	Street Address, City, State, Zip Code
SOUTHSIDE CARE CENTER	2644 ALDRICH AVENUE SOUTH MINNEAPOLIS, MN 55408

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **01/10/2012**	ID Prefix	Correction Completed **12/30/2011**	ID Prefix	Correction Completed **01/10/2012**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0012		LSC K0018		LSC K0033	
ID Prefix	Correction Completed **01/12/2012**	ID Prefix	Correction Completed **01/12/2012**	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. #	
LSC K0034		LSC K0039		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/sd	02/29/12	28120	02/03/12
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/29/2011			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00780	A. Building B. Wing	2/21/2012

Name of Facility	Street Address, City, State, Zip Code
SOUTHSIDE CARE CENTER	2644 ALDRICH AVENUE SOUTH MINNEAPOLIS, MN 55408

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **30590** Reg. # **MN Rule 4655.3000 Subp. 1** LSC	Correction Completed **02/21/2012**	ID Prefix **30600** Reg. # **MN Rule 4655.3000 Subp. 4** LSC	Correction Completed **02/21/2012**	ID Prefix **30615** Reg. # **MN Rule 4655.3200 Subp. 1** LSC	Correction Completed **02/21/2012**
ID Prefix **31005** Reg. # **MN Rule 4655.6700** LSC	Correction Completed **02/21/2012**	ID Prefix **31455** Reg. # **MN Rule 4655.9000 Subp.** LSC	Correction Completed **02/21/2012**	ID Prefix **31990** Reg. # **MN Rule 626.557 Subd. 4** LSC	Correction Completed **02/21/2012**
ID Prefix **31995** Reg. # **MN Rule 626.557 Subd. 4A** LSC	Correction Completed **02/21/2012**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 12/30/2011	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00780	A. BUILDING _____ B. WING _____	R 02/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHSIDE CARE CENTER	2644 ALDRICH AVENUE SOUTH MINNEAPOLIS, MN 55408

(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
{3 000}	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS:	{3 000}		
{3 670}	MN Rule 4655.4000 Subp. 1 & 2 Resident Care Record Subpart 1. Application. This part applies to	{3 670}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00780	A. BUILDING _____ B. WING _____	R 02/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHSIDE CARE CENTER	2644 ALDRICH AVENUE SOUTH MINNEAPOLIS, MN 55408

(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
{3 670}	Continued From page 1 boarding care homes only. Subp. 2. Types of information reported. The care record for each resident shall contain the resident's weight at the time of admission and at least once each month thereafter and a summary completed at least monthly by the person in charge indicating the resident's general condition, actions, attitude, changes in sleeping habits or appetite, and any complaints. A detailed incident report of any accident or injury and the action taken shall be recorded immediately. All dates and times of visits by physicians or podiatrists and visits to clinics, dentists, or hospitals shall be recorded. This MN Requirement is not met as evidenced by:	{3 670}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1Y7T

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00780

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E507**
2.STATE VENDOR OR MEDICAID NO.
(L2) **904343800**

3. NAME AND ADDRESS OF FACILITY
(L3) **SOUTHSIDE CARE CENTER**
(L4) **2644 ALDRICH AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55408**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/30/2011** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **10** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **17** (L18)

13.Total Certified Beds **17** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B,4,8** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
		17		
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Susan Hoven, HFE NE II 02/07/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 02/10/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/26/1978
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS
Sent Health to Tamkia & LSC to Dan K on 2-16-2012 Posted 2-16-2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

CCN# 24E507

At the time of the standard survey completed December 30, 2011, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

The facility's request for waiver of the following requirements has been approved:

- F354 - 42 CFR 483.30(b) - Seven day registered nurse coverage
- F458 - 42 CFR 483.70(d)(1)(ii) - Resident room size requirements

See attached Fire Safety Evaluation System (FSES) for the Life Safety Code results.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 8135

January 20, 2012

Mr. Mark Anderson, Administrator
Southside Care Center
2644 Aldrich Avenue South
Minneapolis, Minnesota 55408

RE: Project Number SE507021

Dear Mr. Anderson:

On December 30, 2011, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Gloria Derfus
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792

Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 9, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by February 9, 2012 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by March 30, 2012 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 30, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

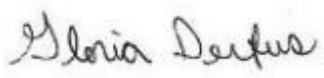
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3792 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File E507s12.rtf

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

PRINTED: 01/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING ______ B. WING ______	12/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHSIDE CARE CENTER	2644 ALDRICH AVENUE SOUTH MINNEAPOLIS, MN 55408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157	The administrator developed and implemented a policy & procedure for suicide prevention. Staff has reviewed this new policy. Resident #7 was seen by psychiatrist NP on 2/2/12. Adjustments were made to her medications. Resident #7 has not expressed any additional thoughts since the initial 10/11/11 documented event. D.O.N. to monitor by daily conversation [illegible] RECEIVED FEB - 3 2012 LICENSING & CERTIFICATION DIVISION OF FACILITY & PROVIDER COMPLIANCE	1/22/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 2/2/12

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

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F 157	Continued From page 1 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed ensure the physician was notified of change in conditions for 1 of 1 resident (R7) in the sample who displayed suicidal ideation. Findings include: R7 was admitted to the facility on 7/28/11, with diagnoses which included: schizophrenia affective disorder, borderline intellectual functioning, psychological stress, and bipolar. R7 was started on Zyprexa (used for long term treatment for schizophrenia) one tablet by mouth as needed for agitation on 10/04/11. The physician for R7 was not notified of the suicidal thoughts. The director of nursing (DON) completed the Individual Abuse Prevention Plan Susceptibility to Abuse Checklist dated 10/10/11. The behavior R7 had expressed included suicidal thoughts or actions. The documentation indicated the resident verbalized these thoughts occasionally. Additional behaviors were exhibited included personal habit patterns which were offensive and antisocial, such as poor personal hygiene, offensive odor or nudity, and psychotic behavior such as	F 157		

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

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F 157	Continued From page 2 hallucinations or delusions. The annual minimum data set dated 10/10/11, indicated the resident exhibited symptoms of depression which were feelings of death, feelings about herself, and feeling down and depressed. The symptoms were identified as occurring daily. R7 was not an on any antidepressant medications. R7's record indicated on 10/11/11, DON had interviewed the resident and had asked the question if the resident ever thought she would be better off dead or wanted to hurt herself in some way. The resident replied, "Yes, every day." Then the resident started to cry. The writer then gave the resident a hug and asked why the resident was so sad, the resident stated, "I don't know." The writer then asked the resident if she was lonely and the resident replied, "Yes." The resident was then asked if she wanted to talk and the resident indicated she just wanted water. The writer offered to come back and check on the resident. The DON informed the nurse on duty and then left a note for the head licensed practical nurse (LPN). The medical record lacked evidence that R7's physician and/or the DON were notified of the depressed mood state. The program manager was interviewed at 4:00 p.m. on 12/29/11, and the program revealed R7's physician was never notified the suicidal ideation.	F 157		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or	F 225		

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F 225	Continued From page 3 mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to investigate and report an injury of	F 225	All staff have been retrained and received additional education on the policy and procedure for abuse/maltreatment prevention and reporting. The staff was retrained also in the requirements of reporting within 24 hours to their supervisor and administrator. Abuse investigations will follow the State's guidelines including the online reporting process. Administrator to monitor.	1/29/12

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F 225	Continued From page 4 unknown origin for 1 of 1 resident (R12) in the sample and failed to investigate and report resident to resident altercations for 1 of 3 residents (R8) which involved R9 and R2. Findings include: R12 was admitted to the facility on 11/24/03, with diagnoses which included: depression, hemiplegia - presumed cerebral palsy, and breast cancer. R12 had a history of leaving the facility without signing out and returning to the facility intoxicated. In addition, R12 had a history of falls and injuries when drinking. R12 was returned to the facility on 5/3/11, by the police and had an open area about the size of a quarter on her left forehead. The incident was not thoroughly investigated or reported to the state agency. On 5/3/11, in the evening (no time given), R12 was returned to the facility by police and the police reported that someone found R12 lying in front of the laundromat. An open area about the size of a quarter was noted on her left forehead and the resident was intoxicated. Review of the incident report indicated there was no further investigation of the incident. R12's care plan dated 11/8/11, indicated the resident had behavior flare-ups and excessive alcohol intake occasionally and the resident could be verbally abusive to other residents/staff. The interventions consisted of advising the resident to quit alcohol and teach R12 that alcohol increased symptoms of depression. R12's individual abuse prevention plan dated 11/7/11, indicated the resident exhibited self-injuries behaviors or self - inflicted abuse with alcohol. R12 exhibited	F 225		

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F 225	Continued From page 5 offensive or antisocial behavior when intoxicated. The program manager (PM) was interviewed at 4:00 p.m. on 12/28/11, and confirmed the facility had not investigated the incident. The facility did not know who the resident was out with, nor did the facility know where R12 had obtained the alcohol. The program manager verified the incident had not been reported. The director of nursing (DON) was interviewed at 9:30 a.m. on 12/29/11, and indicated the facility cannot force a resident to stay home and the police are questioning the facility as to "Why is she at the facility like this?" The DON indicated the police have told the facility they should think about a different location for R12. The DON indicated the facility did not have to call in the report because it did not happen while the resident was in the facility. The DON revealed the incident was not reported to the state agency. R8 was admitted to the facility on 4/29/11, with diagnoses which included: schizoaffective disorder - bipolar type, diabetes mellitus, and hypertension. R8 had an altercation with R9 on a transportation bus at 1:30 p.m. on 6/23/11. The incident was not thoroughly investigated and was not reported to the state agency. R9 had been admitted to the facility on 6/23/11, with the diagnoses which included: schizoaffective disorder - bipolar type and diabetes. The quarterly Minimum Data Set (MDS) dated 12/6/11, revealed R9 was able to verbally make her needs known. Document review indicated R8 had an altercation	F 225		

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F 225	Continued From page 6 with R9 on a transportation bus. R9 reported to the staff that R8 had hit her with her fist on the upper right buttock while they were on the bus. There were two witnesses to the incident. R8 denied hitting R9. The investigative part of the report indicated the staff that was with R8 and R9 did not see the incident. Both R8 and R9 gave a different account of the incident. The PM was interviewed at 4:00 p.m. on 12/28/11, and confirmed there was no documentation staff had assessed and investigated R9's right upper buttocks where the R9 had reported she had been hit by R8's fist. The PM confirmed the incident had not been reported and he did not believe R8 had hit R9. The DON was interviewed at 9:30 a.m. on 12/28/11, indicated she was not sure if the incident on 6/23/11, between R8 and R9 should have been reported. R8 had an altercation with R2 on the first floor kitchen at 4:30 p.m. on 11/19/11. The incident was not reported to the state agency. R2 was admitted to the facility on 4/20/98, with diagnosis of Epilepsy/seizure disorder. The quarterly MDS dated 10/9/11, revealed R2 was able to make her needs known and was able to understand with clear comprehension. The incident report on 11/19/11, indicated R8 and R2 had an altercation in the kitchen at 4:30 p.m. R8 pushed R2 and then hit her right arm. R2 then hit R8 on the right side of her face. Staff was passing medications and heard screaming. Staff ran to the kitchen and another resident (not	F 225		

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F 225	Continued From page 7 identified) indicated that R8 stated, "Yes it was R8 who started the fight". R8 said, "Why does everybody lie on me?" R2 indicated, "That bitch hit me in my face for no reason at all." R2 claimed a broken jaw. R2 was sent to the emergency room via police. The investigation indicated R8 had a mental decomposition due to refusing psychotropic medications. The PM confirmed during an interview at 4:00 p.m. on 12/29/11, that the state agency was not notified. The program director also confirmed there were no incidents reported to the state agency in the past year. The DON was interviewed at 9:30 a.m. on 12/28/11, indicated the incident on 11/19/11, between R8 and R2 should have been reported. The administrator/owner was interviewed at 1:35 p.m. on 12/29/11. The administrator confirmed the facility could do better in following up on incidents and investigating all incidents. The administrator agreed the incident on 5/3/11, should have been reported to the state agency.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on document review, policy review and interview, the facility failed to follow the facility's	F 226	All staff has been retrained and received additional education on the policy and procedure for abuse/maltreatment prevention and reporting. The staff was retrained also in the requirements of reporting within 24 hours to their supervisor and Administrator. Abuse investigations will follow the State's guidelines including the online reporting process. Administrator to monitor. will review to make sure policies are followed.	1/29/12

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F 226	Continued From page 8 Vulnerable Adult Policy for investigating and reporting injury of unknown origin for 1 of 1 resident (R12) and for resident to resident altercation for 3 of 3 residents (R9, R8, and R2) in the sample. Findings include: R12 was admitted to the facility on 11/24/03, with diagnoses which included: depression, hemiplegia - presumed cerebral palsy, and breast cancer. R12 had a history of leaving the facility without signing out and returning to the facility intoxicated. In addition, R12 had a history of falls and injuries when drinking. R12 was returned to the facility on 5/3/11, by the police and had an open area about the size of a quarter on her left forehead. The incident was not thoroughly investigated or reported to the state agency. On 5/3/11, in the evening (no time given), R12 was returned to the facility by police and the police reported that someone found R12 laying in front of the laundromat. An open area about the size of a quarter was noted on her left forehead and the resident was intoxicated. Document review of the incident report indicated there was no further investigation of the incident. The program manager (PM) was interviewed at 4:00 p.m. on 12/28/11, and confirmed the facility had not investigated the incident. The facility did not know who the resident was out with, nor did the facility know where R12 had obtained the alcohol. The program manager verified the incident had not been reported. The director of nursing (DON) was interviewed at	F 226		

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F 226	Continued From page 9 9:30 a.m. on 12/29/11, and indicated the facility cannot force a resident to stay home and the police are questioning the facility as to "Why is she at the facility like this?" The DON indicated the police have told the facility they should think about a different location for R12. The DON indicated the facility did not have to call in the report because it did not happen while the resident was in the facility. The DON revealed the incident was not reported to the state agency. R8 was admitted to the facility on 4/29/11, with diagnoses which included: schizoaffective disorder - bipolar type, diabetes mellitus, and hypertension. R8 had an altercation with R9 on a transportation bus at 1:30 p.m. on 6/23/11. The incident was not thoroughly investigated and was not reported to the state agency. R9 had been admitted to the facility on 6/23/11, with diagnoses which included: schizoaffective disorder - bipolar type and diabetes. The quarterly Minimum Data Set (MDS) dated 12/6/11, revealed R9 was able to verbally make her needs known. Documentation review indicated R8 had an altercation with R9 on a transportation bus. R9 reported to the staff that R8 had hit her with her fist on the upper right buttock while they were on the bus. There were two witnesses to the incident. R8 denied hitting R9. The investigative part of the report indicated the staff who was with R8 and R9 did not see the incident. Both R8 and R9 gave a different account of the incident. The PM was interviewed at 4:00 p.m. on 12/28/11, and confirmed there was no	F 226		

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F 226	Continued From page 10 documentation that staff had assessed and investigated R9's right upper buttocks where the R9 had reported she had been hit by R8's fist. The PM confirmed the incident had not been reported and he did not believe that R8 had hit R9. The DON was interviewed at 9:30 a.m. on 12/28/11, indicated she was not sure if the incident on 6/23/11, between R8 and R9 should have been reported. R8 had an altercation with R2 on the first floor kitchen at 4:30 p.m. on 11/19/11. The incident was not reported to the state agency. R2 was admitted to the facility on 4/20/98, with diagnosis which included: Epilepsy/seizure disorder. The quarterly MDS dated 10/9/11, revealed R2 was able to make her needs known and was able to understand with clear comprehension. The incident report on 11/19/11, indicated R8 and R2 had an altercation in the kitchen at 4:30 p.m. R8 pushed R2 and then hit her right arm. R2 then hit R8 on the right side of her face. Staff was passing medications and heard screaming. Staff ran to the kitchen and another resident (not identified) indicated that R8 stated, "Yes, it was R8 who started the fight". R8 said, "Why does everybody lie on me?" R2 indicated, "That bitch hit me in my face for no reason at all." R2 claimed a broken jaw. R2 was sent to the emergency room via police. The investigation indicated R8 had a mental decomposition due to refusing psychotropic medications.	F 226		

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F 226	Continued From page 11 The PM confirmed during an interview at 4:00 p.m. on 12/29/11, that the state agency was not notified. The program director also confirmed there were no incidents reported to the state agency in the past year. The DON was interviewed at 9:30 a.m. on 12/28/11, indicated the incident on 11/19/11, between R8 and R2 should have been reported. At 12:06 p.m. on 12/28/11, the activities director was interviewed on abuse training. The Activities Director indicated staff are given verbal training on abuse at the time of hire. Staff are given an in-service yearly, which included a paper test on abuse, and then discussed abuse with the staff. The administrator/owner was interviewed at 1:35 p.m. on 12/29/11. The administrator confirmed the facility could do better in following up on incidents and investigating all incidents. The administrator agreed the incident on 5/3/11, should have been reported to the state agency. A review of the facility's policy on Vulnerable Adult (VA) / Abuse Investigation (Rev 2010) indicated all reports of resident abuse, neglect, misappropriation of resident property, and injuries of an unknown source shall be promptly reported to state agency and thoroughly investigated. The policy indicated that the facility's internal investigation shall consist of: a) A review of the completed incident report; b) An interview with the person (s) reporting the incident, c) Interviews with any witnesses to the incident; d) An interview with the resident;	F 226		

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F 226	Continued From page 12 e) An interview with the resident's attending physician (if necessary) and review of the resident's medical record; f) An interview with staff members (on all shifts having contact with the resident during period of the alleged incident; g) Interviews with the resident's roommate family members, and visitors (if necessary); h) Interviews with other residents to which the accused employee provides care or services; and i) A review of all circumstances surrounding the incident An interview with the administrator at 4:15 p.m. on 12/29/11, confirmed the facility was not following their policy on investigation and reporting incidents.	F 226		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide clean and sanitary environment in all three common bathrooms that had the potential to affect half of the 17 residents, staff and visitors. In addition, the facility failed to ensure two bedside lamps were in good repair in room 102, and walls and pipes were clean and sanitary in room 205. Findings include:	F 253	All noted maintenance issues have been repaired and corrected. Administrator has developed and implemented preventive maintenance inspections, policy and procedures. This new system will identify and make repairs in a timely fashion. Administrator to monitor by Random audits time frames Adm's PD will conduct walk throughs daily.	1/25/12

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F 253	Continued From page 13 The environmental tour was done at 12:45 p.m. on 12/28/11, with the Administrator (Admin) and program manager (PM). The following were observed: The small bathroom doorway on the first floor had missing paint on the both sides approximately three feet high from the bottom, and the bare wood was exposed, making it an uncleanable surface. The sewer system pipe also had white paint missing and the dark gray metal was exposed on an area which measured approximately four inches wide by three inches. The cabinet under the sink in the big bathrooms on both floors had the bottom particle board (made of wood shavings and sawdust) showing, which had rough surface that resulted in an uncleanable surface. The Administrator verified the findings and stated the white plastic cover board came away. The toilet in the common bathroom located on the second floor, was missing caulking around the base. In room 102, the bedside lamps for two residents were mounted on the wall and were located above the head of bed. The lamps were loose and coming away from the wall. The PM stated as residents pull on the light cords the lamps came loose. In room 205 there was dust debris hanging off the textured sealing, and the exposed pipe line above the bed had dark, black oily hand prints on it. The PM stated the pipe line was not cleaned after they worked on the sprinkling system. There were exposed pipe lines (for water, heating system and	F 253		

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F 253	Continued From page 14 sewer system) through the whole building mainly in the hallways noted with a layer of dark dust on them. The Admin and PM verified the above findings and stated they do have a preventative maintenance program. The Admin also stated he did monthly rounds through the whole building to identify problems. He also stated the process for getting notified was for staff, residents, or visitors was to fill out the Input To Quality Form and give it to the nurse who than was to forward the form to the Admin. The monthly rounds form completed by the Admin on 12/1/11, 11/16/11, and 10/2/11, were reviewed. The above findings were not identified on these forms. Requested the preventative maintenance policy at 1:00 p.m. on 12/28/11, and was not received. The Admin stated at 1:45 p.m. on 12/29/11, that he could not find it.	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine;	F 272	The Registered Dietician will monitor and assess R18 on a monthly basis. The weight loss policy and procedure has been revised and reviewed by all staff. Interventions within the policy will be further utilized to promote a stable and appropriate weight for R18. Weekly weighing of the resident will occur and be recorded. The care plan will be updated and reviewed regularly until weight is stabilized. D.O.N. to monitor. Significant wt loss procedure will develop	2/9/12

All NS & sign wt loss will be assessed by the RD. PD will alert RD & wt loss of 5 pounds ~ 30.

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F 272	Continued From page 15 Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess and determine effective interventions for weight loss for 1 of 1 (R18) resident with weight loss. Findings include: R18 was admitted on 10/11/11, from the hospital with diagnoses which included paranoid	F 272		

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F 272	Continued From page 16 schizophrenia, diabetes, and hypertension. The facility did not comprehensively assessed R18 after having three months of weight loss. R18 was observed eating at 5:35 p.m. on 12/27/11, R18 received two bowls of soup and ate both bowls of soup. At 12:10 p.m. on 12/29/11, R18 had scalloped potatoes and vegetables, approximately 12 ounces of each served. R18 ate 75% of the food served and did not request any other food. The Admission Weight Data for R18 was: Date: 10/11/2011; Weight: 160; Date: 11/07/2011; Weight: 155; Date: 12/09/2011; Weight: 149; The resident loss 3.13% from the first weight to the second weight. The resident loss 6.88% from the first weight to the third weight. The admission minimum data set dated 10/18/11, indicated R18 was not on a weight loss program. The care area assessment (CAA) dated 10/20/11, had the nutrition area trigger. The CAA summary noted resident was on a non concentrated sweets diet but also stated that she was a vegetarian. R18 had been witnessed eating meat and went into the kitchen and ate a hamburger patty. Staff provided R18 with a diet of her choice, however, she refused most foods due to it being the wrong brand or cooked in a manner she did not think was proper. The facility had the registered dietician (RD) speak with her but resident refused. The noted indicated staff continue to attempt to get foods that the resident likes and offer options at meals.	F 272		

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F 272	Continued From page 17 The RD nutritional assessment documented on 10/15/11, assessment was not able to be completed as resident refused to talk with her. R18's weight was noted to be 160 and an ideal body weight range (IBWR) was 121.5 to 148.5 pounds. The food preferences and dislikes noted R18 had very specific food preferences which included wild rice (only type of rice), black beans (not canned), couscous with yellow carrots, red peppers and sea salt (twice daily, with black beans at main meal). Also indicated R18 liked hummus and David's cucumber salad (brand name). The comments noted discussed at length R18's preferences and then R18 refused to answer any other questions. On 11/29/11, the RD noted discussed affects of food on blood glucose and R18 insisted that 500 was normal for her because she was African. "Resident was noted as drinking excessive liquids (soy milk and juice), cook was diluting juice to reduce effect on blood glucose." The nursing weekly progress notes were reviewed. The note dated 10/14/11, done by the program director (PD) indicated R18 was on no concentrated sweet diet but she claimed she was vegetarian and mostly wants her own kind of foods. "Eats moderate amount and drinks plenty of water." The appetite was just fair and no weight recorded. The next progress note dated 11/11/11, indicated, "Claims she was a vegetarian but has been seen eating chicken and other meats. Very picky eater. Often would want her own kind of food not even on the menu and staff try to meet her needs, then she declined what was offered. Weight was 155 and appetite poor but at times eats ok." The progress note dated 12/12/11,	F 272		

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F 272	Continued From page 18 done by staff nurse noted weight 149 down six pounds from last month and "resident being picky eater with a poor appetite." R18 was hospitalized 12/14/11 to 12/17/11, with high blood glucose and her weight on 12/17/11, at the hospital was noted to be 137. R18 was admitted back to the facility on 12/17/11, with a weight of 137. Since R18's admission date of 10/11/11 through 12/17/11, R18 lost 23 pounds without a comprehensive assessment. The PD was interviewed at 10:20 a.m. on 12/29/11, the weight loss was expected because she does not eat the food and R18 thought she was fat. Then she started to demand other foods which the facility brought for her and still refused. He did notice the weight loss. He asked the RD to talk about her food request but was unable to recall if he mentioned R18's weight loss. The PD stated he had not talked with the RD about the weight loss as he thought things were going better. The PD stated he should have made sure the RD reviewed R18's weights but he missed it. The RD was asked at 9:45 a.m. on 12/29/11, if she had knowledge of the weight loss and she stated no but would look into it. R18's weight loss was not comprehensively assessed as the RD was not informed of the weight loss by the nursing staff.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279		

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	24E507	A. BUILDING ______ B. WING ______	12/30/2011

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F 279	Continued From page 19 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to develop a comprehensive plan of care 1 of 1 resident (R7) for suicide thoughts. Findings include: R7's plan of care did not contain any interventions for the exhibited signs of mood. R7 was admitted to the facility on 7/28/11, with diagnoses which included: schizophrenia affective disorder, borderline intellectual functioning, psychological stress, and bipolar. R7 was started on Zyprexa (used for long term treatment for schizophrenia) one tablet by mouth as needed for agitation on 10/04/11. R7 was not an on any antidepressant medications.	F 279	The revised care plan now includes using the interventions that are contained in the newly implemented suicide prevention policy and procedure. Nursing staff members have reviewed this change to the care plan. Resident and medications reviewed by NP on 2/2/12. D.O.N. to monitor. by reviewing daily communication log of any comments [illegible] depending on severity SS will notify MD & pharmacist to review med. [illegible] will be [illegible]	2/3/12

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F 279	Continued From page 20 The director of nursing (DON) completed the Individual Abuse Prevention Plan Susceptibility to Abuse Checklist dated 10/10/11. The behavior R7 had expressed included suicidal thoughts or actions. The documentation indicated the resident verbalized these thoughts occasionally. Additional behaviors that were exhibited included personal habit patterns which were offensive and antisocial, such as poor personal hygiene, offensive odor or nudity, and psychotic behavior such as hallucinations or delusions. The annual minimum data set dated 10/10/11, indicated the resident exhibited symptoms of depression which were feelings of death, feelings about herself, and feeling down and depressed. The symptoms were identified as occurring daily. R7's record indicated on 10/11/11, DON had interviewed the resident and had asked the question if the resident ever thought she would be better off dead or wanted to hurt herself in some way. The resident replied, "Yes, every day." Then the resident started to cry. The writer then gave the resident a hug and asked why the resident was so sad, the resident stated, "I don't know." The writer then asked the resident if she was lonely and the resident replied, "Yes." The resident was then asked if she wanted to talk and the resident indicated she just wanted water. The writer offered to come back and check on the resident. The DON informed the nurse on duty and then left a note for the head licensed practical nurse (LPN). The medical record lacked evidence that R7's physician and/or the DON were notified of the depressed mood state. R7's care plan dated 10/11/11, was reviewed and	F 279		

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F 279	Continued From page 21 did not indicate any interventions for the exhibited signs and symptoms of depression. The DON was interviewed at 1:30 p.m. on 12/28/11, and confirmed that the resident did not have a comprehensive care plan done relating sadness, suicidal thoughts, and harm to self after R7 indicated that she had been having thoughts of suicide daily.	F 279		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess and determine effective interventions for weight loss for 1 of 1 (R18) resident in the sample who had weight loss. Findings include: R18 was admitted on 10/11/11, from the hospital with diagnoses which included: paranoid schizophrenia, diabetes, and hypertension. R18	F 325	The Registered Dietician will continue to monitor and assess the diet of Resident 18. The weight loss policy was reviewed with Program Director and registered Dietician for further strategies to improve food intake. The resident will be weighed weekly and weights will be recorded. Dietary nutritional supplements will be offered to Resident 18. D.O.N. to monitor. to communicate [illegible] wt loss. RD will [illegible] p̄ 5 pound loss in 30 day.	2/3/12

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F 325	Continued From page 22 was not on a weight loss program. The facility did not assess R18 after having three months of weight loss. R18 was observed eating at 5:35 p.m. on 12/27/11. R18 was served tow bowls of soup and finished the entire amount. At 12:10 p.m. on 12/29/11, she had scalloped potatoes and vegetables approximately 12 ounces of each served. R18 ate 75% of the food served and did not request any other food. The Admission Weight Data for R18 was as follows: Date: 10/11/2011; Weight: 160; Date: 11/07/2011; Weight: 155; Date: 12/09/2011; Weight: 149; The resident lost 3.13% from the first weight to the second weight. The resident lost 6.88% from the first weight to the third weight. The registered dietician (RD) nutritional assessment documented on 10/15/11, assessment was not able to be completed as resident refused to talk with her. R18's weight was noted to be 160 and an ideal body weight range (IBWR) was 121.5 to 148.5 pounds. The food preferences and dislikes noted R18 had very specific food preferences which included wild rice (only type of rice), black beans (not canned), couscous with yellow carrots, red peppers and sea salt (twice daily, with black beans at main meal). Also indicated R18 liked hummus and David's (brand name) cucumber salad. The comments noted discussed at length R18's preferences and then R18 refused to answer any	F 325		

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F 325	Continued From page 23 other questions. The admission minimum data set dated 10/18/11, indicated R18 was not on a weight loss program. The care area assessment (CAA) dated 10/20/11, had the nutrition area trigger. The CAA summary noted resident was on a non-concentrated sweets diet but also stated she was a vegetarian. The CAA noted, "Name had been witnessed eating meat and went into the kitchen and ate a hamburger patty. Staff provided R18 with a diet of her choice; however, she refused most foods due to it being the wrong brand or cooked in a manner she did not think was proper. The RD tried to speak with her but resident refused. Staff continue to attempt to get foods that the resident likes and offer options at meals." The care plan dated 10/18/11, noted in the problem of eating section that R18 was on a no concentrated sweets diet and claimed to be a vegetarian. It had a list of special foods she wanted to be served, such as chocolate soy milk, black olives, avocado, and vegetarian burgers. The approaches included that R18, "Claimed to be a vegetarian but eats meat and chicken. Does not take a tray rather wants foods served in a bowl or cup, advised on the importance of eating a balanced meal for good health." The nursing weekly progress notes were reviewed. The note dated 10/14/11, done by the program director (PD) indicated R18 was on no concentrated sweet diet but she claims she was vegetarian and mostly wants her own kind of foods. "Eats moderate amount and drinks plenty of water." The appetite was just fair and no weight	F 325		

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F 325	Continued From page 24 recorded. The next progress note dated 11/11/11, by the PD indicated claims she was a vegetarian but had seen eating chicken and other meats. "Very picky eater." "Often would want her own kind of food not even on the menu and staff try to meet her needs, then she declined what was offered. Weight was 155 and appetite poor but at times eats ok." The progress note dated 12/12/11, done by staff nurse noted weight 149 down six pounds from last month and "resident being picky eater with a poor appetite." R18 was hospitalized 12/14/11, to 12/17/11, with high blood glucose and her weight on 12/17/11, at the hospital was noted to be 137. R18 was admitted back to the facility on 12/17/11, with a weight of 137. Since R18's admission date of 10/11/11, through 12/17/11, R18 lost 23 pounds without a comprehensive assessment. The facility cook was interviewed at 9:50 a.m. at 12/28/11, and he stated R18 would be offered all the menu items and alternatives. He was aware of her vegetarian diet but she will ask for hot dogs on occasion. He stated the facility had purchased special food she requested but she would refuse to eat them once she was served. The PD was interviewed at 10:20 a.m. on 12/29/11, the weight loss was expected because she does not eat the food and R18 thought she was fat. Then she started to demand other foods which the facility brought for her and still refused. He did notice the weight loss. He asked the RD to talk about her food request but was unable to recall if he mentioned R18's weight loss. The PD stated he had not talked with the RD about the weight loss as he thought things were going	F 325		

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F 325	Continued From page 25 better. The PD stated he should have made sure the RD reviewed R18's weights but he missed it. The RD was asked at 9:45 a.m. on 12/29/11, if she had knowledge of the weight loss and she stated, "No", but would look into it. The undated Weight Loss policy was received from the PD and reviewed. The resident weight loss policy noted, "The goal was to identify causes, provide different interventions and methods to prevent recurrence. Step 2 noted the facility will graph resident weight loss to that of other facilities to compare occurrence rate. Step 3 indicated the members of the quality improvement team that will be working on the quality of care issues. Step 4 was to do a root cause analysis and the director of nursing or licensed practical nurse would review the medications and care plans to determine if any additional care issues were involved. Step 5 to identify residents with current weight loss to provide monitoring and prevent future weight loss. Step 6 was the results of the quality improvement plan." The PD admitted he did not follow all the steps and also verified R18 was not comprehensively assessed for the weight loss.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any	F 329	The administrator developed and implemented a suicide prevention policy procedure for the facility. The Pharmacist will be notified and will assess medications of any resident known to have expressed suicidal thoughts. All staff have reviewed this policy and procedure.	2/1/12

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F 329	Continued From page 26 combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview, document review, the facility failed to comprehensively assess medications related to suicidal thoughts for 1 of 1 resident (R7) and the facility failed follow recommendations from the consultant pharmacist to monitor a weekly pulse rate for 1 of 1 resident (R3), who received a cardiovascular medication. Findings include: The facility had not assessed R7's medications after the resident had expressed that she was sad, had suicidal thoughts and that she would be better off dead. R7 was admitted to the facility on 7/28/11, with diagnoses which included: schizophrenia affective disorder, borderline intellectual	F 329	The consulting Pharmacist will initiate a change for the pharmacy's medical records department to be certain any vital signs needed for medication or treatment sheets. Pulse vital signs will be taken and recorded as noted on medication sheets. Pharmacist to monitor.	

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F 329	Continued From page 27 functioning, psychological stress, and bipolar. R7 was started on Zyprexa (used for long term treatment for schizophrenia) one tablet by mouth as needed for agitation on 10/04/11. The director of nursing (DON) completed the Individual Abuse Prevention Plan Susceptibility to Abuse Checklist dated 10/10/11. The behavior R7 had expressed included suicidal thoughts or actions. The documentation indicated the resident verbalized these thoughts occasionally. Additional behaviors that were exhibited included personal habit patterns which were offensive and antisocial, such as poor personal hygiene, offensive odor or nudity, and psychotic behavior such as hallucinations or delusions. R7's record indicated on 10/11/11, DON had interviewed the resident and had asked the question if the resident ever thought she would be better off dead or wanted to hurt herself in some way. The resident replied, "Yes, every day." Then the resident started to cry. The writer then gave the resident a hug and asked why the resident was so sad, the resident stated, "I don't know." The writer then asked the resident if she was lonely and the resident replied, "Yes." The resident was then asked if she wanted to talk and the resident indicated she just wanted water. The writer offered to come back and check on the resident. The DON informed the nurse on duty and then left a note for the head licensed practical nurse (LPN). The medical record lacked evidence that R7's physician and/or the DON were notified of the depressed mood state. The DON was interviewed at 1:30 p.m. on 12/28/11, and confirmed that the resident did not	F 329		

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F 329	Continued From page 28 have a comprehensive assessment done relating sadness, suicidal thoughts, and harm to self after R7 indicated that she had been having thoughts of suicide daily and the resident's pharmacist had not been notified. R3 received an anti-arrhythmic agent medication, Atenolol 25 milligrams (mg) every day and the facility failed to document a pulse for a resident. Consultative Pharmacist report dated 2/1/11, through 3/3/11, noted the resident was prescribed Atenolol. No pulse was recorded with the weekly blood pressure (BP) in February 2011. The report indicated a recommendation from the pharmacist to, "Please obtain and document a pulse at least weekly." The form was signed off by the DON on 3/9/11. The Program Manager (PM) made a notation on sheet which read, "BPs and pulse scheduled weekly in MAR {medication administration record}." The form was initialed by PM. Treatment logs were reviewed in the chart for the months of March, April, May, June, July, August, September, October, and November 2011; the treatment logs recorded only weight and blood pressure, there was no documentation of a pulse rate in the patients MAR's between March and December 2011. At 10:12 a.m. on 12/29/11, LPN-A verified only BP and weight were being monitored for R3 in the December 2011 Treatment Log. LPN-A then added "ALSO PULSE WEEKLY" to the December 2011 treatment log.	F 329		
F 354 SS=C	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON	F 354	Waiver requested (see attached addendum). Administrator to monitor.	~~2/3/12~~ 1

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

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F 354	Continued From page 29 Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on resident condition, staff interview and facility schedules the facility failed to employ a RN (registered nurse) on a full time basis, for eight consecutive hours, seven days per week. This had the potential to effect all 17 residents in the facility. Findings include: The facility had a waiver for 24 hour licensed nurse coverage and eight hour RN coverage, dated 7/2010. According to the waiver, all 17 residents were ambulatory and capable of self-preservation. The waiver stated the RN provided 15 hours of coverage a week and on-call. At 9:30 a.m. on 12/29/11, the RN stated she works approximately 9-12 hours a week. At 2:00	F 354	Adm will advertise extended hours for RN.	

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F 354	Continued From page 30 p.m. on 12/30/11, the administrator said the facility had not been advertising for a RN.	F 354		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on Interview, document review, the pharmacist did not report any irregularities in the medication regimen related to suicidal thoughts for 1 of 1 resident (R7) in the sample and the pharmacist did not follow up on the recommendation made to monitor at least a weekly pulse rate for 1 of 1 resident (R3) in the sample who was on a cardiovascular medication. Findings include: The facility's consulting pharmacist had not assessed R7's medications after the resident had expressed she was sad, had suicidal thoughts and that she would be better off dead. R7 was admitted to the facility on 7/28/11, with the following diagnoses schizophrenia affective disorder, borderline intellectual functioning,	F 428	Administrator has developed and implemented a suicide prevention policy and procedure to the consultant pharmacist will be notified and will assess medications after learning of any residents with suicidal thoughts. All nursing staff has reviewed the policy. D.O.N. to monitor through Admin daily Communicat log.	2/1/12

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F 428	Continued From page 31 psychological stress, and bipolar. R7 was started on Zyprexa (used for long term treatment for schizophrenia) one tablet by mouth as needed for agitation on 10/04/11. The director of nursing (DON) completed the Individual Abuse Prevention Plan Susceptibility to Abuse Checklist dated 10/10/11. The behavior R7 had expressed included suicidal thoughts or actions. The documentation indicated the resident verbalized these thoughts occasionally. Additional behaviors that were exhibited included personal habit patterns which were offensive and antisocial, such as poor personal hygiene, offensive odor or nudity, and psychotic behavior such as hallucinations or delusions. R7's record indicated on 10/11/11, DON had interviewed the resident and had asked the question if the resident ever thought she would be better off dead or wanted to hurt herself in some way. The resident replied, "Yes, every day." Then the resident started to cry. The writer then gave the resident a hug and asked why the resident was so sad, the resident stated, "I don't know." The writer then asked the resident if she was lonely and the resident replied, "Yes." The resident was then asked if she wanted to talk and the resident indicated she just wanted water. The writer offered to come back and check on the resident. The DON informed the nurse on duty and then left a note for the head licensed practical nurse (LPN). The medical record lacked evidence that R7's physician and/or the DON were notified of the depressed mood state. The facility's consulting pharmacist reviewed R7's medications on two separate occasions (10/19/11	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	12/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHSIDE CARE CENTER	2644 ALDRICH AVENUE SOUTH MINNEAPOLIS, MN 55408

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F 428	Continued From page 32 and 11/30/11) since the resident indicated that she was feeling sad, and that she would be better off dead. The pharmacist indicated there were no changes in the medication. The DON was interviewed at 1:30 p.m. on 12/28/11, and confirmed that the resident did not have a comprehensive assessment done relating sadness, suicidal thoughts, and harm to self after R7 indicated that she had been having thoughts of suicide daily and the resident's pharmacist had not been notified. An interview with the consulting pharmacist was done at 10:30 a.m. on 12/29/11. The pharmacist confirmed they were not aware that R7 had thoughts of suicide, harming herself, and sadness. The facility nursing staff did not inform the pharmacist of the mood state of R7. R3 received an anti-arrhythmic agent medication, Atenolol 25 milligrams (mg) every day. The consultant pharmacist recommended at least a weekly pulse check in March of 2011, but failed to follow-up when it was not being recorded as recommended. Consultative Pharmacist report dated February 1, 2011 through March 3, 2011, noted the resident was prescribed Atenolol. No pulse was recorded with the weekly blood pressure (BP) in February 2011. The report indicated a recommendation from the pharmacist to, "Please obtain and document a pulse at least weekly." The form was signed off by the DON on 3/9/11. The Program Manager (PM) made a notation on sheet which read, "BPs and pulse scheduled weekly in MAR {medication administration record}." The form	F 428		

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F 428	Continued From page 33 was initialed by PM. Treatment logs were reviewed in the chart for the months of March, April, May, June, July, August, September, October, and November 2011; the treatment logs recorded only weight and blood pressure, there was no documentation of a pulse rate in the patients MAR's between March and December 2011. At 10:12 a.m. on 12/29/11, LPN-A verified only BP and weight were being monitored for R3 in the December 2011 Treatment Log. LPN-A then added "ALSO PULSE WEEKLY" to the December 2011 treatment log.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441	Administrator revised and updated the Infection Control surveillance policy and procedure and reviewed with Program Director. The summary report was revised also to include staff and resident trend monitoring. QI Committee to monitor.	2/2/12

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F 441	Continued From page 34 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop a surveillance program to evaluate and implement interventions to assist with decreasing the facility's infection rate. Further, the surveillance documents failed to consistently identify: date of the infection, date signs and symptoms observed, description of signs and symptoms, diagnostic test and date/results, organism identified, antibiotic used, follow up results, if indicated, date of follow up and signature of the staff person completing the form. In addition, the facility failed to develop an employee health surveillance program. This deficient practice has the potential to affect all 17 residents in the facility. Findings include: The Director of Nursing (DON) was interviewed at	F 441		

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F 441	Continued From page 35 9:55 a.m. on 12/29/11, and stated she does not do the infection control surveillance for the facility. She referred the surveyor to the program director (PD). The PD was interviewed at 10:00 a.m. on 12/29/11. He stated when any resident had an infection that required an antibiotic, he recorded it in a book. The book contained a monthly resident infection report sheet. The sheet had columns for the resident name, room number, type of infection and/or date of onset, culture organism, antibiotic name, start, stop, precautions type, start, stop, comments and resolution. PD stated he only tracked the resident if the resident was treated with medication. He stated he does not do a summary or analysis of the monthly sheets. At the Quality Assurance (QA) meeting, he just reads the past three monthly sheets. The previous eight months of resident infection reports were reviewed and it was noted none of the reports were completed. There was not a resolution recorded for 12 entries over the eight months. The precaution type had a key listed which indicated W/S was wound and skin, E was enteric, D was discharge, and R was respiratory. There were five D recorded and two R recorded. The PD stated the R was respiratory and to have the resident cover their cough and good hand washing and the D was discharge from the resident body like urine. The PD stated there was no policy for an infection control surveillance program. The PD did provide a policy dated 11/11, with the subject infection control: classification of infections. The policy was reviewed and was found to be a description of specific type of infections but did not mention infection control surveillance procedure.	F 441		

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F 441	Continued From page 36 The PD stated he did not have an infection control surveillance plan for the staff and did not have a combined report with the residents and staff illness for monitoring of trends.	F 441		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide at least 80 square feet of usable space in 1 of 6 resident bedrooms (Room 102) which included (R5, R7, R12, and R18). Findings include: On the evening of 12/27/11, the day of 12/2811, and the morning of 12/29/11, four residents were observed to reside in room 102. The useable floor space of that room was 310 square feet which provided 77.5 square feet per resident. The room provided a closet, call device and reading light for each resident in room 102. When interviewed all four residents (R5, R7, R12, and R18) stated they liked their room and there was adequate room for them to keep their personal belongings.	F 458	Waiver requested (See attached addendum). Administrator to monitor.	~~2/2/12~~

Southside Care Center
2644 Aldrich Avenue South
Minneapolis, MN 55408
(612) 872-4233

February 2, 2012

To: Gloria Derfus
MN. Department of Health
Facility & Provider Compliance Division

From: Mark J. Anderson
Administrator

Re: Addendum to Plan of Correction - Tag Number F354

A waiver is requested for 1) full time D.O.N.; and 2) R.N. day coverage.

All 17 residents are ambulatory and capable of self-preservation. None have serious health problems. A signed statement from each resident's primary physician supporting this is on file in the resident's medical record.

Adequate and continuity of care is maintained for all residents by the long term staff of the facility who have 24 hour phone access to the Medical Director, Director of Nursing (cell), Program Director, and the Administrator (cell).

The goal is to achieve the following two week nursing staffing schedule:

Day shift	7-3	LPN coverage 14 days
P.M. shift	3-11	LPN coverage 12 days
2 days		TMA coverage
Night shift		TMA coverage

Director of Nursing 15 hours per week and on-call.
Administrator 5 hours per week and on-call
Advertising and recruitment for this position has begun and should result in a hiring a person by 8/15/10.

A competitive and prevailing salary has been offered in the past when nursing positions have been advertised. Advertisements are on file.

Please contact me if you have any need for further information or have any questions.

Sincerely,

Mark J. Anderson
Administrator, Southside Care Center

Southside Care Center
2644 Aldrich Ave. South
Minneapolis, MN. 55408

To: Gloria Derfus
MDH

From: Mark J. Anderson MJA
Administrator

RE: Addendum to Plan of Correction
Tag Number F468

February 2, 2012

Room Size Waiver Request-F458

The facility is requesting a waiver for MN> Rule 4660.1430, sub.2. Built-in closets were added to provide a larger, more adequate storage space for each resident in room 102. These closets have changed the useable floor area to less than the required 80 square feet. An on-going assessment procedure is being used whenever a new resident moves into the room. This assessment will help ensure adequate space for the residents. Program Director will monitor.

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Wednesday, February 01, 2012 3:18 PM
To: 'rochi_lsc@cms.hhs.gov'
Cc: Rexeisen, Robert (DPS); 'mja@sttheresenh.org'; RImholteFiresafe@aol.com; 'Colleen Leach'; 'Jim Loveland'; Leppke, Susan (MDH); 'Mark Meath'; 'Mary Henderson'; 'Shellae Dietrich'; Steege, Nicole (MDH); Whitney, Marian (DPS)
Subject: Southside Care Center (24E507) FSES

This is to inform you that I am accepting the FSES report submitted by Southside Care Center as a part of their POC for the fire inspection conducted on 12-29-11. This FSES report shows that Southside CC has attained a passing score in each of the three zones evaluated. The exit date was 12-30-11.

I am recommending that CMS approve this FSES.

Patrick Sheehan, Fire Safety Supervisor
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division, Est. 1905
Office: 651-201-7205, Cell: 651-470-4416
FAX: 651-215-0525
Web: fire.state.mn.us

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

FE507020

PRINTED: 01/19/2012
FORM APPROVED
OMB NO. 0938-0391

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, SOUTHSIDE CARE CENTER was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: PATRICK SHEEHAN, SUPERVISOR HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145 Pat.Sheehan@state.mn.us	K 000	RECEIVED JAN 31 2012 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION POC ok w/FSE for K18, K33, K34 + K39 PS 2-1-12	

DC: 02.08.12

EXIT: 12.30.11

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

[signature] | Administrator | 1/30/2012

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

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K 000	Continued From page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. SOUTHSIDE CARE CENTER is a 2-story building with a full basement. The building was constructed 1909 and was determined to be of Type V(000) construction. This building is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 17 beds and had a census of 16 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1	K 012	Correction not needed Southside Care Center has achieved a passing FSE2 score (see attached FSES/HC) Administrator to monitor	1/10/12

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K 012	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation, this building does not meet the requirement for construction type and height. This deficient practice could affect all occupants including residents, staff and visitors. Findings include: On facility tour between 10:30 AM and 12:00 PM on 12/29/2011, observation revealed that this 2-story, wood frame facility of Type V(000) construction does not meet the minimum construction requirements for a building of this height. This deficient practice was verified by the manager at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 012		
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations	K 018	The hinges and door latch were adjusted to allow for proper closing and latching. Program Director to monitor.	12/30/11

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K 018	Continued From page 3 in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility had corridor doors that did not meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3.2. This deficient practice could affect the residents. Findings include: During facility tour between 10:30 AM and 12:00 PM on 12/29/2011, observation revealed that the door to resident room 205 has damaged hinges preventing the door from closing without excessive force. This deficient practice was verified by the manager at the time of the inspection.	K 018		
K 033 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1	K 033	Correction not needed Southside Care Center has achieved a passing FSES score (see enclosed FSES/HC) Administrator to monitor	1/10/2012

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K 033	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation, the stairway enclosure of this facility does not meet the required one (1) hour fire resistive construction. This deficient practice could affect all occupants including residents, staff and visitors. Findings include: On facility tour between 10:30 AM and 12:00 PM on 12/29/2011, observation revealed that the wall of the stair enclosures are constructed of plaster on wood lath on wood studs, which does not meet minimum the requirements for this type of facility. This deficient practice was verified by the manager at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 033		
K 034 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the stairwells in accordance with LSC (2000) Chapter 7.2. This deficient practice could affect all residents.	K 034	correction not needed. Southside Care Center has achieved a passing FSES score (see enclosed FSES/HC) Administrator to monitor	1/12/2012

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K 034	Continued From page 5 Findings include: On facility tour between 10:30 AM and 12:00 PM on 12/29/2011, observation revealed that the back stairs at the rear exit are only 32" wide. This deficient practice was verified by the manager at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 034		
K 039 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 This STANDARD is not met as evidenced by: Based on observation and interview, the second floor corridor does not meet the minimum 48" width requirement. This deficient practice could affect all residents. Findings include: During a tour of the facility between 10:30 AM and 12:00 PM on 12/29/2011, observation revealed that the first floor corridor is only 33 inches in clear width and not the 48 inches required for this type of facility. This deficient practice was verified by the manager at the time of the inspection.	K 039	correction not needed Southside Care Center has achieved a passing FSES score. (see enclosed FSES/HC) Administrator to monitor	1/12/2012

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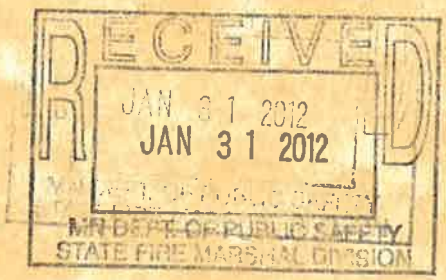
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHSIDE CARE CENTER	2644 ALDRICH AVENUE SOUTH MINNEAPOLIS, MN 55408

(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 039	Continued From page 6 Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 039		



Report of Consultant FSES Findings

Southside Care Center

Date of Survey: January 10, 2012

Prepared by:
Robert L. Imholte, President
Fire Safety Resources, LLC
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Cold Spring, MN 56320
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Fire Safety Resources, LLC
Consulting, Education & Inspection Services

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E-mail: RImholteFiresafe@aol.com

Mr. Mark Anderson
Administrator
Southside Care Center
2644 Aldrich Avenue South
Minneapolis, Minnesota 55408

January 17, 2012

RE: FSES at Southside Care Center

Dear Mr. Anderson:

Enclosed please find the survey information relating to the fire safety evaluation of Southside Care Center, 2644 Aldrich Avenue South in Minneapolis conducted on 01/10/12. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(01), *Guide to Alternative Approaches to Life Safety*.

As you're aware, the FSES is a rating system designed to evaluate the level of fire/life safety in health care facilities and serves as a method to demonstrate alternative compliance with the 2000 edition of the *Life Safety Code*® (NFPA 101). An FSES was made necessary in this case because of deficiencies cited against the facility relating to:

- K012 – Construction type and height,
- K033 – Exit stairway enclosure construction,
- K034 – Exit stairway width, and
- K039 – First Floor corridor width.

The following factors served as the basis for this evaluation:

- The building, constructed in 1909, was considered an existing building.
- Southside Care Center is two stories in height and has a full basement. For purposes of this FSES, each of the three levels was treated as a separate zone.
- For purposes of this FSES, it was assumed that the basement level does not involve resident housing, treatment or customary access.

Based on the conditions found during the 01/10/12 FSES survey, all four parameters in Table 7 of the FSES worksheets, ZONE FIRE SAFETY EQUIVALENCY EVALUATION, in all three zones evaluated were found to have a score of zero or greater. *Fire Safety Resources* finds, therefore, that Southside Care Center has achieved a passing FSES score. Should you have any questions or need additional information, please don't hesitate to get back to me.

Wishing you a safe day!

Robert L. Imholte

Robert L. Imholte, President
Fire Safety Resources, LLC

Enclosures

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

Form Approved
OMB No. 0938-0242

ZONE 1 OF 3 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
Southside Care Center	01- Main Building
ZONE(S) EVALUATED: Basement	
PROVIDER/VENDOR NO.: 24E507	DATE OF SURVEY: 01/10/12

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.
A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factors 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 1 Year and Younger		
	Risk Factor	1.0		1.2		

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.
A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.
B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

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

Step 3: Compute Adjusted Building Status (R) - Use Table 2.
A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.
B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.
C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X		=	

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X	1.6	=	1

*** FIRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers.**

SURVEYOR SIGNATURE: Robert L. Imhoff, Fire Safety Resources, LLC	TITLE: President	DATE: 01/17/12
FIRE AUTHORITY SIGNATURE: [signature]	TITLE: Fire Safety Supervisor / State Fire Marshal	DATE: 2-1-12

Step 4: Determine Safety Parameter Values - Use Table 4.

A. Select and circle the safety value for each safety parameter in Table 4 that best describes the conditions in the zone. Choose only one value for each of the 13 parameters. If two or more appear to apply, choose the one with the lowest point value.

TABLE 4.

Safety Parameters	Safety Parameters Values						
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II		
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433
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 Clos.			
	-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	1	
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.				
			<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	Mech. Assisted Systems by Zone				
	-5(0)[c]	0	3				
10. Emergency Movement Routes	<2 Routes	Multiple Routes					
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)		
	(-8)	-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)				

NOTE:

[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.

For SI units: 1 ft = 0.3048 m

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200")

[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.

Step 5: Compute Individual Safety Evaluations – Use Table 5.

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as ½ the corresponding value circled in Table 4.

B. Add the four columns, keeping in mind that any negative numbers deduct.

C. Transfer the resulting total values for S_1, S_2, S_3, S_G to blocks labeled S_1, S_2, S_3, S_G in Table 7 on page 4 of this sheet.

TABLE 5. 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/Walls	1			1
5. Doors to Corridor	2		2	2
6. Zone Dimensions			0	0
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			-8	-8
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		3	3	3
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 12	S_2= 8	S_3= 5	S_4= 9

TABLE 6.
MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
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	18	9	19(16)[a]	6	11(8)[a]	3

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

b. For a 2nd story zone location in a sprinklered EXISTING facility, 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: S_a=7, S_b=10, and S_c=7

Step 6: Determine Mandatory Safety Requirement Values - Use Table 6.

A. Using the classification of the building (i.e., New or Existing) and the floor where the zone is located circle the appropriate value in each of the three columns in Table 6.

B. Transfer the three circled values from Table 6 to the blocks marked S_a, S_b, and S_c in Table 7.

C. 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.

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION								Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 12	−	S_a 9	= C 3	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 8	−	S_b 6	= E 2	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 5	−	S_c 3	= P 2	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 9	−	R 1	= G 8	√	

TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET				
Complete one copy of this worksheet for each facility. For each consideration, select and mark the appropriate column.		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	√		
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.			√
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.	√		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	√		
E.	There are no flue-fed incinerators.	√		
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.	√		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	√		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	√		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	√		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	√		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	√		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			√

CONCLUSIONS

1. ☒ All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the *Life Safety Code*.*

2. ☐ One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the *Life Safety Code*.*

*The equivalency covered by this worksheet includes the majority of considerations covered by the *Life Safety Code*. There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

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

Form Approved
OMB No. 0938-0242

ZONE 2 OF 3 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
Southside Care Center	01-Main Building
ZONE(S) EVALUATED: First Floor	
PROVIDER/VENDOR NO.: 24E507	DATE OF SURVEY: 01/10/12

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.
A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factors 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 1 Year and Younger		
	Risk Factor	1.0		(1.2)		

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.
A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.
B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	1.0	X	1.5	X	1.1	X	4.0	X	1.2	=	7.9

Step 3: Compute Adjusted Building Status (R) - Use Table 2.
A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.
B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.
C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)

F		R
1.0 X		=

TABLE 3B. (EXISTING BUILDINGS)

F		R	
0.6 X	7.9	= 4.7	= 5

*** FIRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers.**

SURVEYOR SIGNATURE: Robert S. Imhotte — Fire Safety Resources, LLC	TITLE: President	DATE: 01/17/12
FIRE AUTHORITY SIGNATURE: [signature]	TITLE: Fire Safety Supervisor / State Fire Marshal	DATE: 2-1-12

Step 4: Determine Safety Parameter Values - Use Table 4.

A. Select and circle the safety value for each safety parameter in Table 4 that best describes the conditions in the zone. Choose only one value for each of the 13 parameters. If two or more appear to apply, choose the one with the lowest point value.

TABLE 4.

Safety Parameters	Safety Parameters Values						
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II		
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433
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 Clos.	
	-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	1
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.				
			<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	Mech. Assisted Systems by Zone				
	-5(0)[c]	0	3				
10. Emergency Movement Routes	<2 Routes	Multiple Routes					
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)		
	(-8)	-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)				

NOTE:

[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.

For SI units: 1 ft = 0.3048 m

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200")

[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.

Step 5: Compute Individual Safety Evaluations – Use Table 5.

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as ½ the corresponding value circled in Table 4.

B. Add the four columns, keeping in mind that any negative numbers deduct.

C. Transfer the resulting total values for S_1, S_2, S_3, S_G to blocks labeled S_1, S_2, S_3, S_G in Table 7 on page 4 of this sheet.

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

TABLE 6.
MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
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	18	9	19(16)[a]	6	11(8)[a]	3

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

b. For a 2nd story zone location in a sprinklered EXISTING facility, 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: S_a=7, S_b=10, and S_c=7

Step 6: Determine Mandatory Safety Requirement Values - Use Table 6.

A. Using the classification of the building (i.e., New or Existing) and the floor where the zone is located circle the appropriate value in each of the three columns in Table 6.

B. Transfer the three circled values from Table 6 to the blocks marked S_a, S_b, and S_c in Table 7.

C. 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.

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION								Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 16	−	S_a 5	= C 11	✓	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 13	−	S_b 4	= E 9	✓	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 4	−	S_c 1	= P 3	✓	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 13	−	R 5	= G 8	✓	

TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET				
Complete one copy of this worksheet for each facility. For each consideration, select and mark the appropriate column.		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	✓		
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.			✓
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.	✓		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	✓		
E.	There are no flue-fed incinerators.	✓		
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.	✓		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	✓		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	✓		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	✓		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	✓		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	✓		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			✓

CONCLUSIONS

1. ☒ All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the *Life Safety Code*.*

2. ☐ One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the *Life Safety Code*.*

*The equivalency covered by this worksheet includes the majority of considerations covered by the *Life Safety Code*. There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

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

Form Approved
OMB No. 0938-0242

ZONE 3 OF 3 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
Southside Care Center	01-Main Building
ZONE(S) EVALUATED	
Second Floor	
PROVIDER/VENDOR NO.	**DATE OF SURVEY**
24E507	01/10/12

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.
A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factors 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 1 Year and Younger		
	Risk Factor	1.0		(1.2)		

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.
A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.
B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	1.0	X	1.2	X	1.2	X	4.0	X	1.2	=	6.9

Step 3: Compute Adjusted Building Status (R) - Use Table 2.
A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.
B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.
C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)

F		R
1.0 X		=

TABLE 3B. (EXISTING BUILDINGS)

F		R
0.6 X	6.9	= 4.1 = 5

*** FIRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers.**

SURVEYOR SIGNATURE	TITLE	DATE
Robert J. Umstattd — Fire Safety Resources, LLC	President	01/17/12
FIRE AUTHORITY SIGNATURE	**TITLE**	**DATE**
Fire Safety Supervisor	State Fire Marshal	2-1-12

Step 4: Determine Safety Parameter Values - Use Table 4.

A. Select and circle the safety value for each safety parameter in Table 4 that best describes the conditions in the zone. Choose only one value for each of the 13 parameters. If two or more appear to apply, choose the one with the lowest point value.

TABLE 4.

Safety Parameters	Safety Parameters Values						
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II		
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433
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 Clos.			
	-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	1	
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.				
			<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	Mech. Assisted Systems by Zone				
	-5(0)[c]	0	3				
10. Emergency Movement Routes	<2 Routes	Multiple Routes					
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)		
	(-8)	-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)				

NOTE:

[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.

For SI units: 1 ft = 0.3048 m

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200")

[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.

Step 5: Compute Individual Safety Evaluations – Use Table 5.

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as ½ the corresponding value circled in Table 4.

B. Add the four columns, keeping in mind that any negative numbers deduct.

C. Transfer the resulting total values for S_1, S_2, S_3, S_G to blocks labeled S_1, S_2, S_3, S_G in Table 7 on page 4 of this sheet.

TABLE 5. 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/Walls	0			0
5. Doors to Corridor	1		1	1
6. Zone Dimensions			0	0
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			-8	-8
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		3	3	3
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 10	S_2= 8	S_3= 4	S_4= 7

TABLE 6.
MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
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	18	9	19(16)[a]	6	11(8)[a]	3

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

b. For a 2nd story zone location in a sprinklered EXISTING facility, 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: S_a=7, S_b=10, and S_c=7

Step 6: Determine Mandatory Safety Requirement Values - Use Table 6.

A. Using the classification of the building (i.e., New or Existing) and the floor where the zone is located circle the appropriate value in each of the three columns in Table 6.

B. Transfer the three circled values from Table 6 to the blocks marked S_a, S_b, and S_c in Table 7.

C. 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.

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION								Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 10	−	S_a 9	= C 1	✓	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 8	−	S_b 6	= E 2	✓	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 4	−	S_c 3	= P 1	✓	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 7	−	R 5	= G 2	✓	

TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET				
Complete one copy of this worksheet for each facility. For each consideration, select and mark the appropriate column.		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	✓		
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.			✓
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.	✓		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	✓		
E.	There are no flue-fed incinerators.	✓		
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.	✓		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	✓		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	✓		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	✓		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	✓		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	✓		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			✓

CONCLUSIONS

1. ☒ All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the *Life Safety Code*.*

2. ☐ One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the *Life Safety Code*.*

*The equivalency covered by this worksheet includes the majority of considerations covered by the *Life Safety Code*. There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

FIRE SAFETY EVALUATION

Name of Facility: Southside Care Center
Address: 2644 Aldrich Avenue South, Minneapolis, MN 55408
Phone: 612-872-4233
Licensed capacity: 17
Census at time of survey: 16

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

What follows is a report on the results of a fire safety evaluation of the above-named facility that was conducted during an on-site visit to the facility between 0850 hours and 1135 hours on 01/10/12. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(01), *Guide to Alternative Approaches to Life Safety*. Based on this evaluation, Southside Care Center has achieved a passing score on the FSES.

In addition to the 01/10/12 walkthrough of the facility, the findings outlined herein are based on information provided by Mr. Mark Anderson, Administrator; Mr. Emmanuel Tandoh, Program Director; and Mr. Mike Kelley, Maintenance.

Initial Comments:
Southside Care Center was constructed in 1909 and is considered an existing building for federal certification purposes. The facility was, therefore, treated as such for assigning values on the FSES worksheets.

The building was assigned a construction type of Type V(000). Construction type was determined based on the following information. The flat roof is supported by wood joists. Exterior walls consist of plaster on wood lath on wood studs (some wire mesh was also found); in some places gypsum wallboard has been added. Interior walls and ceilings are constructed of plaster on wood lath on wood studs; again, in some places gypsum wallboard has been added. The exception is in the basement, where some exposed wood joists were found in the ceiling.

The facility's residents are not allowed in the basement. For purposes of this FSES, therefore, it was assumed that this level does not involve resident housing, treatment or customary access and it was scored accordingly in performing the FSES calculations.

Southside Care Center is two stories in height and has a full basement. It is protected by a supervised, wet-pipe automatic fire sprinkler system. For purposes of this FSES, each of the three levels was treated as a separate zone. With the exception of Table 8, which applies to all zones, this narrative will address each of the three zones separately. A review of records revealed that:

- The building's fire alarm system underwent a complete annual check by Nardini Fire Equipment Company, Inc. on 03/03/11,
- The building's wet-pipe sprinkler system underwent a complete annual check by Viking Automatic Sprinkler Company on 03/07/11, and
- The sprinklers in the building were changed to quick-response heads on 06/04/08.

This report is intended to serve as an explanation of how the scores entered on Tables 1, 4 and 8 of the FSES worksheets (see Forms CMS-2786T enclosed) were arrived at. The score assigned to each item is noted in brackets ([ ]). It must be noted that numbers were rounded to the nearest tenth of a point and that measurements of over one-half inch were rounded to the nearest inch. To ensure that the FSES addresses the "worst-case scenario", the product of the multiplication in Table 3B (i.e. value of "R") was rounded up to the nearest whole number. Code references are provided where appropriate. Codes referenced include the 2001 edition of NFPA 101A and the 2000 edition of the *Life Safety Code*® (NFPA 101).

All Levels – TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

In accordance with NFPA 101A(01), Sec. 4.7, Step 8, only one copy of this table is required to be filled out for the building. For convenience, however, this table was filled out on the worksheets for all three zones evaluated.

All items in Table 8 were checked 'Met' with the exception of Items B and L, which were checked 'Not Applicable'. Because Southside Care Center is an existing facility (Item B) and does not meet the definition of a high rise (Item L), these two items do not apply in this case. The remaining items were checked 'Met' based on the following:

- Building utilities and heating and air conditioning systems appear to be in conformance with NFPA 101(00), Sections 9.1 and 9.2.
- No space heaters or incinerator were found.
- The facility's evacuation plan and fire drill records were reviewed and appeared to be in order.
- The facility's smoking regulations were reviewed and appeared to be in order.
- Draperies, cubicle curtains, upholstered furniture, mattresses and decorations were found to be in accordance with NFPA 101(00), Sec. 19.7.5.
- Portable fire extinguishers, EXIT signage and emergency lighting appeared to be provided and maintained in accordance with applicable requirements.

Zone 1 – Basement Level:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

According to information provided by Mr. Tandoh, the facility's residents are not allowed in the basement. For purposes of this FSES, therefore, it was assumed that this level did not involve resident housing, treatment or customary access. The basement was found to house a staff office, the facility heating plant, storage and a laundry area. As a result, in accordance with instruction given in NFPA 101A(01), Sec. 4.3.2(4)a, only Item 3, Zone Location (*L*), of Table 1 was addressed and the value of factor *F* in Table 2, OCCUPANCY RISK FACTOR CALCULATION, was assigned a factor of 1.6 (i.e. the value assigned to basements in factor *L* of Table 1).

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -7]:
   Because of exposed wood joists found in the basement ceiling, the building was assigned a Type V(000) construction type.

Because this coverage is not included in any of the categories of NFPA 101A(01), Sections 4.6.12.2 through 4.6.12.5, this Parameter was scored as "None".

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

Zone 2 – First Floor:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 1.0]: It was reported that all residents housed in this zone are capable of removing themselves from danger exclusively by their own efforts. A review of the facility's admission policy and current Form CMS-672 and interview with the administrator confirmed that the facility will only admit residents who are ambulatory and capable of going up and down stairs without assistance.
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to seven (7) residents in this zone. The zone also contains the facility living/dining room, which is available for use by all 17 residents.
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 4.0]: There is one (1) staff person on duty on the night shift. Because this staff person leaves the floor to make rounds of the building every 2 hours, this Parameter was scored as "One or More over None".
5. Patient Average Age (*A*) [Value assigned = 1.2]: This score was assigned to address the "worst-case scenario". Only one (1) of the residents currently housed in this zone is over 65 years of age. Three (3) other residents who use the living/dining room area are also over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -2]:
   Because of exposed wood joists found in the basement ceiling, the building was assigned a Type V(000) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Interior finish was found to be plaster or gypsum wallboard or a combination thereof.
3. Interior Finish (Rooms) [Score: +3]:
   Interior finish was found to be plaster or gypsum wallboard or a combination thereof.
4. Corridor Partitions/Walls [Score: +1]:
   Corridor walls are constructed of ½-inch thick gypsum wallboard installed over plaster on wood lath on both sides of wood studs, which likely provides a fire resistance of at least ½-hour.
5. Doors to Corridor [Score: +1]:
   Corridor doors were found to be of 1-3/4-inch solid wood construction. The bathroom doors were found to be of hollow core wood construction, but pursuant to direction given in NFPA 101A(00), Sec. 4.6.5, these doors were not considered in classifying doors to corridors, as no flammable or combustible materials were found in the rooms.

6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. The building measures approximately 70 feet in length on this level and Parameter 10 was assigned a score of -8. There is only one complying means of egress out of this level, which creates a dead-end condition.
7. Vertical Openings [Score: 0]:
   While the self-closing door opening from the kitchen into the west stairway was found to be a 90-minute fire-rated assembly (including a metal frame), the stair enclosure walls are constructed of plaster on wood lath/gypsum wallboard on wood studs, which likely does not provide the 1-hour fire resistance required by NFPA 101(00), Sec. 19.3.1.1.
8. Hazardous Areas [Score: 0]:
   Hazardous areas were found to be sprinkler protected as required by NFPA 101A(01), Sec. 4.6.8.2 and smoke-separated as required by NFPA 101(00), Sec. 19.3.2.1.
9. Smoke Control [Score: 0]:
   This score was assigned per Footnote c to this Table (fewer than 31 residents).
10. Emergency Movement Routes [Score: -8]:
    While there are two ways out of this level, access to the rear (west) exit passes through the kitchen, which does not meet the requirements of NFPA 101(00), Sec. 7.5.1.7. From the kitchen, occupants must pass through a door that opens into the west stairway enclosure from the Second Floor. The door to the exterior from this enclosure is only 30.5 inches in clear width. The following deficient conditions were also noted:
    - The corridor narrows to 32 inches clear width because of the desk serving as the nurse station,
    - Resident room doors were found to be only 29.5 inches in clear width and, therefore, could not be credited as an egress route [see NFPA 101A(01), Sec. 4.6.10.3.2].
11. Manual Fire Alarm [Score: +2]:
    There are manual fire alarm pull stations at the front and back doors. The fire alarm system is monitored by Nardini Fire Equipment Company.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in NFPA 101A(01), Sec. 4.6.13.4.3 and Footnote *g* to this Table. The zone is protected with quick-response sprinklers. System-connected smoke detectors were found in the Day Room/Dining Room area and in the corridors leading to the main entrance and to the kitchen. This was scored as "Corridor Only" smoke detection. Battery-operated single station smoke detectors were found in the resident sleeping rooms.
13. Automatic Sprinklers [Score: +10]:
    The building is protected by a supervised, wet-pipe automatic fire sprinkler system consisting of quick-response sprinklers.

Zone 3 – Second Floor:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 1.0]: It was reported that all residents housed in this zone are capable of removing themselves from danger exclusively by their own efforts. A review of the facility's admission policy and current Form CMS-672 and interview with the administrator confirmed that the facility will only admit residents who are ambulatory and capable of going up and down stairs without assistance.
2. Patient Density (*D*) [Value assigned = 1.2]: There is bed capacity for up to ten (10) residents in this zone.
3. Zone Location (*L*) [Value assigned = 1.2]: This zone is one floor height above First Floor.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 4.0]: There is only one (1) staff person on duty on the night shift. This staff person is located on First Floor, but makes rounds of the building every 2 hours.
5. Patient Average Age (*A*) [Value assigned = 1.2]: This score was assigned to address the "worst-case scenario". Only three (3) of the residents currently housed in this zone are over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -7]:
   Because of exposed wood joists found in the basement ceiling, the building was assigned a Type V(000) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Interior finish was found to be plaster or gypsum wallboard or a combination thereof.
3. Interior Finish (Rooms) [Score: +3]:
   Interior finish was found to be plaster or gypsum wallboard or a combination thereof.
4. Corridor Partitions/Walls [Score: 0]:
   Corridor walls are constructed of ½-inch thick gypsum wallboard installed over plaster on wood lath on both sides of wood studs. Because it appears that the corridor walls do not extend to the underside of the roof above, they were graded as "< ½ hour" in accordance with NFPA 101A(01), Sec. 4.6.4.2.
5. Doors to Corridor [Score: +1]:
   Corridor doors were found to be of 1-3/4-inch solid wood construction. The door to the bathroom was found to be of hollow core wood construction, but pursuant to direction given in NFPA 101A(00), Sec. 4.6.5, this door was not considered in classifying doors to corridors, as no flammable or combustible materials were found in the room.

   [***Note***: A review of a *Draft Summary of Deficiencies* from a fire/life safety recertification survey conducted on 12/29/11 revealed that the facility is to be issued a K018 deficiency for the corridor door into Resident Room 205, which was found to have damaged hinges preventing the door from closing without the use of excessive force. At the time of this FSES survey, it was found that the hinges had been adjusted and the door could be easily closed and latched without the use of excessive force.]

6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. The building measures approximately 70 feet in length on this level and Parameter 10 was assigned a score of -8. Due to the lack of complying means of egress out of this level, a dead-end condition is created.
7. Vertical Openings [Score: 0]:
   Twenty-minute-rated self-closing doors in steel frames were found at the top of the east and west stairways. The vertical openings, therefore, provide protection of less than the 1-hour fire resistance required by NFPA 101(00), Sec. 19.3.1.1
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.
9. Smoke Control [Score: 0]:
   This score was assigned per Footnote c to this Table (fewer than 31 residents).
10. Emergency Movement Routes [Score: -8]:
    There are two ways out of this level. However, as indicated in Item 7, Vertical Openings, the stair enclosures serving this level currently provide protection of less than 1-hour fire resistance, which does not meet the requirements of NFPA 101(00), Sections 7.2.2.5.1 and 7.1.3.2. The following deficient conditions were also noted:
    - The door to the exterior from the rear (west) stair enclosure is only 30.5 inches in clear width.
    - The door at the top of the front (east) stair enclosure, which used to swing over the stairs, was found to have been changed to swing into the corridor, which does not meet the requirements of NFPA 101(00), Sec. 7.2.1.4.3, and
    - Resident room doors were found to measure between 29 and 30 inches in clear width and, therefore, could not be credited as an egress route [see NFPA 101A(01), Sec. 4.6.10.3.2].
11. Manual Fire Alarm [Score: +2]:
    One manual fire alarm pull station was found at the door to the west stair. This appears to meet the intent of Exception No. 1 to NFPA 101(00), Sec. 19.3.4.2. The fire alarm system is monitored by Nardini Fire Equipment Company.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in NFPA 101A(01), Sec. 4.6.13.4.3 and Footnote *g* to this Table. The zone is protected with quick-response sprinklers. A system-connected smoke detector was found in the corridor. Battery-operated single station smoke detectors were found in the resident sleeping rooms.
13. Automatic Sprinklers [Score: +10]:
    The building is protected by a supervised, wet-pipe automatic fire sprinkler system consisting of quick-response sprinklers.

* * * * * * * * * * * *

It must be noted that the scores and values assigned to the parameters in the tables on the FSES worksheets were based on conditions found between 0850 hours and 1135 hours on 01/10/12. Any changes in those conditions after that date could affect those scores and values, either positively or negatively. Again, based on this evaluation, Southside Care Center **has** achieved a passing score on the FSES. No other assessment of the level of safety in this facility is either intended or implied by *Fire Safety Resources, LLC*.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 8135

January 20, 2012

Mr. Mark Anderson, Administrator
Southside Care Center
2644 Aldrich Avenue South
Minneapolis, Minnesota 55408

Re: Enclosed State Boarding Care Home Licensing Orders - Project Number SE507021

Dear Mr. Anderson:

The above facility survey was completed on December 30, 2011 for the purpose of assessing compliance with Minnesota Department of Health Boarding Care Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Boarding Care Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Gloria Derfus

Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3792 Fax: (651) 201-3790

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

E507s12lic.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00780	A. BUILDING _____ B. WING _____	12/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHSIDE CARE CENTER	2644 ALDRICH AVENUE SOUTH MINNEAPOLIS, MN 55408

(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
3 000	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On December 27, 28, 29, and 30, 2011, surveyors of this Department's staff, visited the above provider and the following correction orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the	3 000		

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3 000	Continued From page 1 Minnesota Department of Health, Division of Compliance Monitoring, Licensing and Certification Program; Complaints; 85 East Seventh Place, Suite 220; P.O. Box 64900, St. Paul, Minnesota 55164-0900.	3 000		
3 590	MN Rule 4655.3000 Subp. 2 Tuberculosis Testing of Employees; TB test Subp. 2. Pursuant to Minnesota Rule 4655.1000, and as defined in Minnesota Department of Health Information bulletin 09-03 Tuberculosis Prevention and Control: Nursing Home. Minnesota Rule 4655.3000 Subpart 2 Employee Tuberculosis Program is waived. Conditons of Waiver: - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive baseline TB screening. This screening must include a written assessment of any current TB symptoms, and a two-step tuberculin skin test (TST) or single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON® TB Gold or TB Gold - In Tube, T-SPOT ® .TB). - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive serial TB screening based on the facility 's risk level: (1) low risk - not needed; (2) medium risk - yearly; (3) potential ongoing transmission - consult the Minnesota Department of Health's TB Prevention and Control Program at 651-201-5414. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to review the Tuberculosis (TB) risk assessment annually as documented in the	3 590		

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3 590	Continued From page 2 assessment. The TB risk assessment indicated the faility was not in complaince with the two step skin test for new employees. The deficit practice had the potential to affect all 17 residents in the facility and all staff. Findings include: The Director of Nursing (DON) was interviewed at 9:55 a.m. on 12/29/11, and stated she does not do the infection control surveillance for the facility nor does she due the TB risk assessment. She referred the surveyor to the program director (PD). The PD was interviewed at 10:00 a.m. on 12/29/11, he stated he does monitor the residents for infections and records the information of the resident infection report. The PD stated he did not know the TB risk assessment needed to be reviewed yearly and that the DON was the person whom should have been doing it. The TB risk assessment worksheet was dated 7/10/10, had list the past DON as the person designated to be responsible for implementing an infection-control plan and had not been updated since the current DON started in 12/10. In the reassessment of the TB risk section the frequency was documented at to be done annually with the current date being 7/22/10. The section for screening of the health care workers (HCWs) indicated no baseline skin test was performed with the two step skin test. The frequency was noted on hire and kept in the employee file. The regualtion indicates a two step sklin test was required on hire. The PD was interviewed at 3:45 p.m. on 12/30/11, and stated the new staff only get a one	3 590		

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3 590	Continued From page 3 step at hire and does not get annual mantouxs. Upon review the facility only had two new employees since last survey. S1- date of hire was 9/14/11 and had no record of mantoux bring given or chest x-ray in the file. S2 was hired on 10/13/11, and the mantoux was given 11/14/11. The surveyor reviewed the next hired staff S3 who was hired on 12/29/10, and had mantoux documentation of 10/27/10, in the file. The PD confirmed new staff only recieve a one step mantoux and the missing information in S1 file was do to the staff not bringing in the information. The PD stated they get the mantoux when it can be read when they start. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could monitor to assure TB screening procedures were developed and implemented to ensure staff were free of TB prior to working with residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	3 590		
3 600	MN Rule 4655.3000 Subp. 4 TuberculosisTesting Employees.Docmumentation Subp. 4. Written documentation of compliance. Written documentation of compliance with the above requirements shall be filed in the employee's personnel record. This MN Requirement is not met as evidenced by:	3 600		

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3 600	Continued From page 4 Based on interview and document review the facility failed to review the Tuberculosis (TB) risk assessment annually as documented in the assessment . The TB risk assessment indicated the faility was not in complaince with the two step skin test for new employees. The deficit practice had the potential to affect all 17 residents in the facility and all staff. Findings include: The Director of Nursing (DON) was interviewed at 9:55 a.m. on 12/29/11, and stated she does not do the infection control surveillance for the facility nor does she due the TB risk assessment. She referred the surveyor to the program director (PD). The PD was interviewed at 10:00 a.m. on 12/29/11, he stated he does monitor the residents for infections and records the information of the resident infection report. The PD stated he did not know the TB risk assessment needed to be reviewed yearly and that the DON was the person whom should have been doing it. The TB risk assessment worksheet was dated 7/10/10, had list the past DON as the person designated to be responsible for implementing an infection-control plan and had not been updated since the current DON started in 12/10. In the reassessment of the TB risk section the frequency was documented at to be done annually with the current date being 7/22/10. The section for screening of the health care workers (HCWs) indicated no baseline skin test was performed with the two step skin test. The frequency was noted on hire and kept in the employee file. The regualtion indicates a two step sklin test was required on hire.	3 600		

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3 600	Continued From page 5 Upon review the facility only had two new employees since last survey. S1- date of hire was 9/14/11 and had no record of mantoux bring given or chest x-ray in the file. S2 was hired on 10/13/11, and the mantoux was given 11/14/11. The surveyor reviewed the next hired staff S3 who was hired on 12/29/10, and had mantoux documentation of 10/27/10, in the file. The PD confirmed new staff only recieve a one step mantoux and the missing information in S1 file was do to the staff not bringing in the information. The PD stated they get the mantoux when it can be read when they start. The PD was interviewed at 3:45 p.m. on 12/30/11, and stated the new staff only get a one step at hire and does not get annual mantouxs. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could monitor to assure TB screening procedures were developed and implemented to ensure staff were free of TB prior to working with residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	3 600		
3 615	MN Rule 4655.3200 Subp. 3 Patient or Resident Care Record; duration Subp. 3. Duration and placement of records. Accurate, complete, and legible records for each patient or resident from the time of admission to the time of discharge or death shall be kept current and shall be maintained in a chart holder at the nurses' or attendants' station, a central control point for the storage of records and medications.	3 615		

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3 615	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to review the Tuberculosis (TB) risk assessment annually as documented in the assessment. The deficit practice had the potential to affect all 17 residents in the facility. Findings include: The Director of Nursing (DON) was interviewed at 9:55 a.m. on 12/29/11, and stated she does not do the infection control surveillance for the facility nor does she due the TB risk assessment. She referred the surveyor to the program director (PD). The PD was interviewed at 10:00 a.m. on 12/29/11, he stated he does monitor the residents for infections and records the information of the resident infection report. The PD stated he did not know the TB risk assessment needed to be reviewed yearly and that the DON was the person whom should have been doing it. The TB risk assessment worksheet was dated 7/10/10, the list had the past DON as the person designated to be responsible for implementing an infection-control plan and had not been updated since the current DON started in 12/10. In the re-assessment of the TB risk section, the frequency was documented at to be done annually with the current date being 7/22/10. Suggested Method for Correction: The administrator or designee could review the facility tuberculosis risk assessment annually. Revise the system as needed and educate staff on the system in place. Monitor and review the delivery of the mantouxs and adjust the system as needed.	3 615		

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3 615	Continued From page 7 Time Period for Correction: Twenty one (21) days	3 615		
3 670	MN Rule 4655.4000 Subp. 1 & 2 Resident Care Record Subpart 1. Application. This part applies to boarding care homes only. Subp. 2. Types of information reported. The care record for each resident shall contain the resident's weight at the time of admission and at least once each month thereafter and a summary completed at least monthly by the person in charge indicating the resident's general condition, actions, attitude, changes in sleeping habits or appetite, and any complaints. A detailed incident report of any accident or injury and the action taken shall be recorded immediately. All dates and times of visits by physicians or podiatrists and visits to clinics, dentists, or hospitals shall be recorded. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess and determine effective interventions for weight loss for 1 of 1 (R18) resident with weight loss. Findings include: R18 was admitted on 10/11/11, from the hospital with diagnoses which included paranoid schizophrenia, diabetes, and hypertension. The facility did not comprehensively assessed R18 after having three months of weight loss.	3 670		

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3 670	Continued From page 8 R18 was observed eating at 5:35 p.m. on 12/27/11, R18 received two bowls of soup and ate both bowls of soup. At 12:10 p.m. on 12/29/11, R18 had scalloped potatoes and vegetables, approximately 12 ounces of each served. R18 ate 75% of the food served and did not request any other food. The Admission Weight Data for R18 was: Date: 10/11/2011; Weight: 160; Date: 11/07/2011; Weight: 155; Date: 12/09/2011; Weight: 149; The resident loss 3.13% from the first weight to the second weight. The resident loss 6.88% from the first weight to the third weight. The admission minimum data set dated 10/18/11, indicated R18 was not on a weight loss program. The care area assessment (CAA) dated 10/20/11, had the nutrition area trigger. The CAA summary noted resident was on a non concentrated sweets diet but also stated that she was a vegetarian. R18 had been witnessed eating meat and went into the kitchen and ate a hamburger patty. Staff provided R18 with a diet of her choice, however, she refused most foods due to it being the wrong brand or cooked in a manner she did not think was proper. The facility had the registered dietician (RD) speak with her but resident refused. The noted indicated staff continue to attempt to get foods that the resident likes and offer options at meals. The RD nutritional assessment documented on 10/15/11, assessment was not able to be completed as resident refused to talk with her. R18's weight was noted to be 160 and an ideal	3 670		

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3 670	Continued From page 9 body weight range (IBWR) was 121.5 to 148.5 pounds. The food preferences and dislikes noted R18 had very specific food preferences which included wild rice (only type of rice), black beans (not canned), couscous with yellow carrots, red peppers and sea salt (twice daily, with black beans at main meal). Also indicated R18 liked hummus and David's cucumber salad (brand name). The comments noted discussed at length R18's preferences and then R18 refused to answer any other questions. On 11/29/11, the RD noted discussed affects of food on blood glucose and R18 insisted that 500 was normal for her because she was African. "Resident was noted as drinking excessive liquids (soy milk and juice), cook was diluting juice to reduce effect on blood glucose." The nursing weekly progress notes were reviewed. The note dated 10/14/11, done by the program director (PD) indicated R18 was on no concentrated sweet diet but she claimed she was vegetarian and mostly wants her own kind of foods. "Eats moderate amount and drinks plenty of water." The appetite was just fair and no weight recorded. The next progress note dated 11/11/11, indicated, "Claims she was a vegetarian but has been seen eating chicken and other meats. Very picky eater. Often would want her own kind of food not even on the menu and staff try to meet her needs, then she declined what was offered. Weight was 155 and appetite poor but at times eats ok." The progress note dated 12/12/11, done by staff nurse noted weight 149 down six pounds from last month and "resident being picky eater with a poor appetite." R18 was hospitalized 12/14/11 to 12/17/11, with high blood glucose and her weight on 12/17/11, at the hospital was noted to be 137. R18 was	3 670		

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3 670	Continued From page 10 admitted back to the facility on 12/17/11, with a weight of 137. Since R18's admission date of 10/11/11 through 12/17/11, R18 lost 23 pounds without a comprehensive assessment. The PD was interviewed at 10:20 a.m. on 12/29/11, the weight loss was expected because she does not eat the food and R18 thought she was fat. Then she started to demand other foods which the facility brought for her and still refused. He did notice the weight loss. He asked the RD to talk about her food request but was unable to recall if he mentioned R18's weight loss. The PD stated he had not talked with the RD about the weight loss as he thought things were going better. The PD stated he should have made sure the RD reviewed R18's weights but he missed it. The RD was asked at 9:45 a.m. on 12/29/11, if she had knowledge of the weight loss and she stated no but would look into it. R18's weight loss was not comprehensively assessed as the RD was not informed of the weight loss by the nursing staff. SUGGESTED METHOD OF CORRECTION: After the resident is has been adequately assessed for incontinence, an approriate care plan developed, all staff could be educated to assure that the plan is followed. A reassessment would be appropriate if the residents conditions changes. TIME PERIOD FOR CORRECTION: FOURTEEN (14) DAYS.	3 670		
31005	MN Rule 4655.6700 Acute Illness, Serious Accident, or Death In case of acute illness or serious accident, the	31005		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
31005	Continued From page 11 home shall immediately notify the physician and the family or legal guardian. Apparent deaths shall be reported immediately to the attending physician. This MN Requirement is not met as evidenced by:	31005		
31455	MN Rule 4655.9000 Subp. 1 Housekeeping; General Requirements Subpart 1. General requirements. The entire facility, including walls, floors, ceilings, registers, fixtures, equipment, and furnishings shall be maintained in a clean, sanitary, and orderly condition throughout and shall be kept free from offensive odors, dust, rubbish, and safety hazards. Accumulation of combustible material or waste in unassigned areas is prohibited. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide clean and sanitary environment in all three common bathrooms that had the potential to affect half of the 17 residents, staff and visitors. In addition, the facility failed to ensure two bedside lamps were in good repair in room 102, and walls and pipes were clean and sanitary in room 205. Findings include: The environmental tour was done at 12:45 p.m. on 12/28/11, with the Administrator (Admin) and program manager (PM). The following were	31455		

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	00780	A. BUILDING _____ B. WING _____	12/30/2011

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31455	Continued From page 12 observed: The small bathroom doorway on the first floor had missing paint on the both sides approximately three feet high from the bottom, and the bare wood was exposed, making it an uncleanable surface. The sewer system pipe also had white paint missing and the dark gray metal was exposed on an area which measured approximately four inches wide by three inches. The cabinet under the sink in the big bathrooms on both floors had the bottom particle board (made of wood shavings and sawdust) showing, which had rough surface that resulted in an uncleanable surface. The Administrator verified the findings and stated the white plastic cover board came away. The toilet in the common bathroom located on the second floor, was missing caulking around the base. In room 102, the bedside lamps for two residents were mounted on the wall and were located above the head of bed. The lamps were loose and coming away from the wall. The PM stated as residents pull on the light cords the lamps came loose. In room 205 there was dust debris hanging off the textured sealing, and the exposed pipe line above the bed had dark, black oily hand prints on it. The PM stated the pipe line was not cleaned after they worked on the sprinkling system. There were exposed pipe lines (for water, heating system and sewer system) through the whole building mainly in the hallways noted with a layer of dark dust on them. The Admin and PM verified the above findings and stated they do have a preventative	31455		

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31455	Continued From page 13 maintenance program. The Admin also stated he did monthly rounds through the whole building to identify problems. He also stated the process for getting notified was for staff, residents, or visitors was to fill out the Input To Quality Form and give it to the nurse who than was to forward the form to the Admin. The monthly rounds form completed by the Admin on 12/1/11, 11/16/11, and 10/2/11, were reviewed. The above findings were not identified on these forms. Requested the preventative maintenance policy at 1:00 p.m. on 12/28/11, and was not received. The Administrator stated at 1:45 p.m. on 12/29/11, that he could not find it. SUGGESTED METHOD OF CORRECTION: A communication system could be established to assure staff awareness of needed repairs and cleanliness. The Administrator could designate a staff person responsible to tour and identify mainenance needs. TIME PERIOD FOR CORRECTION: FOURTEEN (14) DAYS.	31455		
31990	MN Rule 626.557 Subd. 4 Reporting Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the	31990		

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31990	Continued From page 14 suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to investigate and report an injury of unknown origin for 1 of 1 resident (R12) in the sample and failed to investigate and report resident to resident altercations for 1 of 3 residents (R8) which involved R9 and R2. Findings include: R12 was admitted to the facility on 11/24/03, with diagnoses which included: depression, hemiplegia - presumed cerebral palsy, and breast cancer. R12 had a history of leaving the facility without signing out and returning to the facility intoxicated. In addition, R12 had a history of falls and injuries when drinking. R12 was returned to the facility on 5/3/11, by the police and had an open area about the size of a quarter on her left forehead. The incident was not thoroughly investigated or reported to the state agency. On 5/3/11, in the evening (no time given), R12 was returned to the facility by police and the police reported that someone found R12 lying in front of the laundromat. An open area about the size of a quarter was noted on her left forehead and the resident was intoxicated. Review of the	31990		

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31990	Continued From page 15 incident report indicated there was no further investigation of the incident. R12's care plan dated 11/8/11, indicated the resident had behavior flare-ups and excessive alcohol intake occasionally and the resident could be verbally abusive to other residents/staff. The interventions consisted of advising the resident to quit alcohol and teach R12 that alcohol increased symptoms of depression. R12's individual abuse prevention plan dated 11/7/11, indicated the resident exhibited self-injuries behaviors or self - inflicted abuse with alcohol. R12 exhibited offensive or antisocial behavior when intoxicated. The program manager (PM) was interviewed at 4:00 p.m. on 12/28/11, and confirmed the facility had not investigated the incident. The facility did not know who the resident was out with, nor did the facility know where R12 had obtained the alcohol. The program manager verified the incident had not been reported. The director of nursing (DON) was interviewed at 9:30 a.m. on 12/29/11, and indicated the facility cannot force a resident to stay home and the police are questioning the facility as to "Why is she at the facility like this?" The DON indicated the police have told the facility they should think about a different location for R12. The DON indicated the facility did not have to call in the report because it did not happen while the resident was in the facility. The DON revealed the incident was not reported to the state agency. R8 was admitted to the facility on 4/29/11, with diagnoses which included: schizoaffective disorder - bipolar type, diabetes mellitus, and hypertension. R8 had an altercation with R9 on a transportation bus at 1:30 p.m. on 6/23/11. The	31990		

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31990	Continued From page 16 incident was not thoroughly investigated and was not reported to the state agency. R9 had been admitted to the facility on 6/23/11, with the diagnoses which included: schizoaffective disorder - bipolar type and diabetes. The quarterly Minimum Data Set (MDS) dated 12/6/11, revealed R9 was able to verbally make her needs known. Document review indicated R8 had an altercation with R9 on a transportation bus. R9 reported to the staff that R8 had hit her with her fist on the upper right buttock while they were on the bus. There were two witnesses to the incident. R8 denied hitting R9. The investigative part of the report indicated the staff that was with R8 and R9 did not see the incident. Both R8 and R9 gave a different account of the incident. The PM was interviewed at 4:00 p.m. on 12/28/11, and confirmed there was no documentation staff had assessed and investigated R9's right upper buttocks where the R9 had reported she had been hit by R8's fist. The PM confirmed the incident had not been reported and he did not believe R8 had hit R9. The DON was interviewed at 9:30 a.m. on 12/28/11, indicated she was not sure if the incident on 6/23/11, between R8 and R9 should have been reported. R8 had an altercation with R2 on the first floor kitchen at 4:30 p.m. on 11/19/11. The incident was not reported to the state agency. R2 was admitted to the facility on 4/20/98, with diagnosis of Epilepsy/seizure disorder. The quarterly MDS dated 10/9/11, revealed R2 was	31990		

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31990	Continued From page 17 able to make her needs known and was able to understand with clear comprehension. The incident report on 11/19/11, indicated R8 and R2 had an altercation in the kitchen at 4:30 p.m. R8 pushed R2 and then hit her right arm. R2 then hit R8 on the right side of her face. Staff was passing medications and heard screaming. Staff ran to the kitchen and another resident (not identified) indicated that R8 stated, "Yes it was R8 who started the fight". R8 said, "Why does everybody lie on me?" R2 indicated, "That bitch hit me in my face for no reason at all." R2 claimed a broken jaw. R2 was sent to the emergency room via police. The investigation indicated R8 had a mental decomposition due to refusing psychotropic medications. The PM confirmed during an interview at 4:00 p.m. on 12/29/11, that the state agency was not notified. The program director also confirmed there were no incidents reported to the state agency in the past year. The DON was interviewed at 9:30 a.m. on 12/28/11, indicated the incident on 11/19/11, between R8 and R2 should have been reported. The administrator/owner was interviewed at 1:35 p.m. on 12/29/11. The administrator confirmed the facility could do better in following up on incidents and investigating all incidents. The administrator agreed the incident on 5/3/11, should have been reported to the state agency. SUGGESTED METHOD OF CORRECTION: The administrator could re-train the staff regarding the policy, and ensure staff were reporting any potential maltreatment immediately (within 24 hours).	31990		

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31990	Continued From page 18 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	31990		
31995	MN Rule 626.557 Subd. 4A Reporting Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on document review, policy review and interview, the facility failed to follow the facility's Vulnerable Adult Policy for investigating and reporting injury of unknown origin for 1 of 1 resident (R12) and for resident to resident altercation for 3 of 3 residents (R9, R8, and R2) in the sample. Findings include: R12 was admitted to the facility on 11/24/03, with diagnoses which included: depression, hemiplegia - presumed cerebral palsy, and breast cancer. R12 had a history of leaving the facility without signing out and returning to the facility intoxicated. In addition, R12 had a history of falls and injuries when drinking. R12 was returned to the facility on 5/3/11, by the police and had an open area about the size of a quarter on her left	31995		

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31995	Continued From page 19 forehead. The incident was not thoroughly investigated or reported to the state agency. On 5/3/11, in the evening (no time given), R12 was returned to the facility by police and the police reported that someone found R12 laying in front of the laundromat. An open area about the size of a quarter was noted on her left forehead and the resident was intoxicated. Document review of the incident report indicated there was no further investigation of the incident. The program manager (PM) was interviewed at 4:00 p.m. on 12/28/11, and confirmed the facility had not investigated the incident. The facility did not know who the resident was out with, nor did the facility know where R12 had obtained the alcohol. The program manager verified the incident had not been reported. The director of nursing (DON) was interviewed at 9:30 a.m. on 12/29/11, and indicated the facility cannot force a resident to stay home and the police are questioning the facility as to "Why is she at the facility like this?" The DON indicated the police have told the facility they should think about a different location for R12. The DON indicated the facility did not have to call in the report because it did not happen while the resident was in the facility. The DON revealed the incident was not reported to the state agency. R8 was admitted to the facility on 4/29/11, with diagnoses which included: schizoaffective disorder - bipolar type, diabetes mellitus, and hypertension. R8 had an altercation with R9 on a transportation bus at 1:30 p.m. on 6/23/11. The incident was not thoroughly investigated and was not reported to the state agency.	31995		

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31995	Continued From page 20 R9 had been admitted to the facility on 6/23/11, with diagnoses which included: schizoaffective disorder - bipolar type and diabetes. The quarterly Minimum Data Set (MDS) dated 12/6/11, revealed R9 was able to verbally make her needs known. Documentation review indicated R8 had an altercation with R9 on a transportation bus. R9 reported to the staff that R8 had hit her with her fist on the upper right buttock while they were on the bus. There were two witnesses to the incident. R8 denied hitting R9. The investigative part of the report indicated the staff who was with R8 and R9 did not see the incident. Both R8 and R9 gave a different account of the incident. The PM was interviewed at 4:00 p.m. on 12/28/11, and confirmed there was no documentation that staff had assessed and investigated R9's right upper buttocks where the R9 had reported she had been hit by R8's fist. The PM confirmed the incident had not been reported and he did not believe that R8 had hit R9. The DON was interviewed at 9:30 a.m. on 12/28/11, indicated she was not sure if the incident on 6/23/11, between R8 and R9 should have been reported. R8 had an altercation with R2 on the first floor kitchen at 4:30 p.m. on 11/19/11. The incident was not reported to the state agency. R2 was admitted to the facility on 4/20/98, with diagnosis which included: Epilepsy/seizure disorder. The quarterly MDS dated 10/9/11, revealed R2 was able to make her needs known and was able to understand with clear	31995		

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31995	Continued From page 21 comprehension. The incident report on 11/19/11, indicated R8 and R2 had an altercation in the kitchen at 4:30 p.m. R8 pushed R2 and then hit her right arm. R2 then hit R8 on the right side of her face. Staff was passing medications and heard screaming. Staff ran to the kitchen and another resident (not identified) indicated that R8 stated, "Yes, it was R8 who started the fight". R8 said, "Why does everybody lie on me?" R2 indicated, "That bitch hit me in my face for no reason at all." R2 claimed a broken jaw. R2 was sent to the emergency room via police. The investigation indicated R8 had a mental decomposition due to refusing psychotropic medications. The PM confirmed during an interview at 4:00 p.m. on 12/29/11, that the state agency was not notified. The program director also confirmed there were no incidents reported to the state agency in the past year. The DON was interviewed at 9:30 a.m. on 12/28/11, indicated the incident on 11/19/11, between R8 and R2 should have been reported. At 12:06 p.m. on 12/28/11, the activities director was interviewed on abuse training. The Activities Director indicated staff are given verbal training on abuse at the time of hire. Staff are given an in-service yearly, which included a paper test on abuse, and then discussed abuse with the staff. The administrator/owner was interviewed at 1:35 p.m. on 12/29/11. The administrator confirmed the facility could do better in following up on incidents and investigating all incidents. The administrator agreed the incident on 5/3/11, should have been reported to the state agency.	31995		

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31995	Continued From page 22 A review of the facility's policy on Vulnerable Adult (VA) / Abuse Investigation (Rev 2010) indicated all reports of resident abuse, neglect, misappropriation of resident property, and injuries of an unknown source shall be promptly reported to state agency and thoroughly investigated. The policy indicated that the facility's internal investigation shall consist of: a) A review of the completed incident report; b) An interview with the person (s) reporting the incident, c) Interviews with any witnesses to the incident; d) An interview with the resident; e) An interview with the resident's attending physician (if necessary) and review of the resident's medical record; f) An interview with staff members (on all shifts having contact with the resident during period of the alleged incident; g) Interviews with the resident's roommate family members, and visitors (if necessary); h) Interviews with other residents to which the accused employee provides care or services; and i) A review of all circumstances surrounding the incident An interview with the administrator at 4:15 p.m. on 12/29/11, confirmed the facility was not following their policy on investigation and reporting incidents. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise the policy, and ensure staff were reporting any potential maltreatment immediately (within 24 hours). The administrator or designee could provide staff training on the policy.	31995		

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31995	Continued From page 23 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	31995		