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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3QR2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00208

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E150**
2.STATE VENDOR OR MEDICAID NO.
(L2) **950842200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GRAND AVENUE REST HOME**
(L4) **3956 GRAND AVENUE S0UTH**
(L5) **MINNEAPOLIS, MN** (L6) **55409**

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 **04/13/2015** (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 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **20** (L18)

13.Total Certified Beds **20** (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: * Code: **A8*** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		20		
(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):
Facility's request for a continuing waiver involving tag K0458 is approved.

17. SURVEYOR SIGNATURE Date :
Mary Heim, HFE NE II 04/17/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 04/17/2015 (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
03/31/1974
(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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/13/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-E150

Electronically Delivered: April 17, 2015

Mr. Allen Soderbeck, Administrator
Grand Avenue Rest Home
3956 Grand Avenue S0uth
Minneapolis, Minnesota 55409

Dear Mr. Soderbeck:

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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective April 12, 2015 the above facility is certified for:

20 - Nursing Facility II Beds

Your request for waiver of F0458 (room size waiver) 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 Medicaid Program.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: April 17, 2015

Mr. Allen Soderbeck, Administrator
Grand Avenue Rest Home
3956 Grand Avenue South
Minneapolis, Minneosta 55409

RE: Project Number SE150024

Dear Mr. Soderbeck:

On March 4, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 13, 2015. 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 April 13, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 11, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 13, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 12, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 13, 2015, effective April 12, 2015 and therefore remedies outlined in our letter to you dated March 4, 2015, will not be imposed.

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

Please contact me if you have any questions about this electronic notice.

Sincerely,

Anne K. Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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
24E150	A. Building B. Wing	4/13/2015

Name of Facility	Street Address, City, State, Zip Code
GRAND AVENUE REST HOME	3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409

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 **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	**04/12/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	**03/09/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	**04/06/2015**
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/AK	04/17/2015	30922	04/13/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/13/2015

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E150	A. Building / B. Wing **01 - MAIN BUILDING 01**	3/11/2015

Name of Facility	Street Address, City, State, Zip Code
GRAND AVENUE REST HOME	3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409

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 **02/16/2015**	ID Prefix	Correction Completed **02/16/2015**	ID Prefix	Correction Completed **02/16/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0012		LSC K0032		LSC K0033	
ID Prefix	Correction Completed **02/16/2015**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0039		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	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	**Reviewed By** PS/AK	**Date:** 04/17/15	**Signature of Surveyor:** 28120	**Date:** 03/11/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/13/2015

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: 3QR2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00208

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E150**
2.STATE VENDOR OR MEDICAID NO.
(L2) **950842200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GRAND AVENUE REST HOME**
(L4) **3956 GRAND AVENUE S0UTH**
(L5) **MINNEAPOLIS, MN** (L6) **55409**

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 **02/13/2015** (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 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **20** (L18)

13.Total Certified Beds **20** (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
___ 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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		20		
(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):
Facility's request for a continuing waiver involving K0458 is recommended.

17. SURVEYOR SIGNATURE Date :
Shawn Soucek, HPR Social Work Specialist 04/10/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 04/13/2015 (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
03/31/1974
(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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: March 4, 2015

Mr. Allen Soderbeck, Administrator
Grand Avenue Rest Home
3956 Grand Avenue South
Minneapolis, Minnesota 55409

RE: Project Number SE150024

Dear Mr. Soderbeck:

On February 13, 2015, 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>Electronic 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:

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gayle.lantto@state.mn.us
Telephone: (651) 201-3794
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 March 25, 2015, 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 March 25, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

• 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 ePoC 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 ePoC 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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 May 13, 2015 (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 August 13, 2015 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 7017

03/27/2015

Mr. Allen Soderbeck, Administrator
Grand Avenue Rest Home
3956 Grand Avenue South
Minneapolis, MN 55409

Re:Project Number SE150024

Dear Mr. Soderbeck:

We have received the form, Statement of Deficiencies and Plan of Correction CMS-2567, which was sent as a result of a survey completed on February 13, 2015 by the survey staff of the Minnesota Department of Health, Health Regulation Division, Licensing and Certification Program.

Evaluation of your submitted Plan of Correction (PoC) indicates your plan is not acceptable as submitted. Specifically the information required for an acceptable PoC is as follows:

F329 A plan of correction for this tag is required. Please state how you will ensure a rationale for medication use is documented and available in each residents' record.

Processing of Federal certification for your facility is being held pending response to this letter. Please refer to your copy of the CMS-2567 form and provide this office with an acceptable written plan modification for the above listed item(s) within five (5) days of the receipt of this letter. Failure to submit the plan modification may result in in a recommendation of termination from Medicare and/or Medicaid program remedies being made to the Centers for Medicare and Medicaid Services Region V Office Minnesota Department of Human Services as appropriate.

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

Please feel free to call me with any questions.

Sincerely,

Gayle Lantto

Gayle Lantto, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Po Box 64900 St Paul Mn 55164-0900
Telephone: (651) 201-3794 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File
Gayle Lantto, Unit Supervisor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 164 SS=F	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164		4/12/15

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

Electronically Signed | 03/10/2015

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

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F 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure privacy for residents during treatments for 4 of 5 residents (R3, R20, R5, R18) whose medication administration was observed, and to to provide privacy visual privacy in multi-resident rooms, and for 1 of 1 resident (R13) who had a visitor, but had the potential to affect all 18 residents residing in the facility. Findings include: R20 was observed receiving a foot treatment with cream while seated in a chair at the front entryway to the facility on 2/9/14 at approximately 11:30 a.m. The entryway was approximately four by five feet in size. R3 was administered genteal eye drops on 2/10/15, at 8:45 a.m. by a licensed practical nurse (LPN)-B. The following day at 8:41 a.m. genteal drops were again administered to R3 by the director of nursing (DON) while R3 sat in chair in entry way at the front door main entrance. R18 received two insulin injection in his abdomen on 2/10/15, at 11:58 a.m. by LPN-B. R18's shirt was lifted and the resident's abdomen was visible as the resident sat in a chair in the entryway.	F 164	After interviewing the residents in question, the residents really were not bothered by the location where these treatments were done. The privacy information noted in this document is from the MDS which is generic and easily taken out of context. Also, the information about resident R10 is inaccurate. It is true that the social worker took the resident to a coffee shop. It is not true that the resident spent any money. The social worker and resident decided to go to the coffee shop because they were monopolizing our limited private meeting space for 2-3 hours at a time and wished to continue this. With that being said, there is definitely room for improvement. The nurse who did not follow facility policy and gave an insulin injection in a open space visible to the hallway has been reprimanded and retrained. We will conduct an additional nursing in-service training on resident privacy with treatments and medications for all current and new nurses. The DON will implement and monitor this and the Administrator will oversee. We are creating a privacy space for	

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F 164	Continued From page 2 LPN-B did not encourage the resident to receive the injection in a more private place. During medication administration times observed on 2/9/15, 2/10/15, and 2/11/15, staff and other residents came to the entryway or passed through the entryway multiple times while residents received treatments or medications in the entry way. Outsiders and staff members also entered and left via the front door while residents received treatments in the entryway area. During the observations, at no time did the person administering treatments ask if the location was acceptable, or encourage a more private area to perform the treatments. R3's annual Minimum Data Set (MDS) dated 1/14/15, indicated R3 had intact cognition and privacy was "somewhat important" to her. R3's MDS also indicated R3's diagnoses included anxiety. R20's annual MDS dated 11/7/14, indicated R20 had intact cognition and that privacy was "somewhat important" to her. R20's MDS also indicated R20's diagnoses included anxiety, depression and schizophrenia. R5's annual MDS dated 12/7/14, indicated R5 had intact cognition with delusions and noted privacy was "very important" to her. R5's MDS also indicated R5's diagnoses included diabetes, anxiety, depression, and schizophrenia. R18's quarterly MDS dated 1/3/15, indicated R18 had intact cognition. R18's MDS also indicated R18's active diagnoses included diabetes, anxiety and depression.	F 164	providing treatments when necessary in the space outside of the nursing office. This is the same space where the treatments have been done. We are installing a privacy curtain that can be pulled shut when needed. Use of this screen will be included in the in-service training. We will be completing and updating a privacy assessment during the initial care planning or the quarterly update care interview with each resident. In the privacy assessment, we will ask the resident about any issues that may have experienced and how we can better meet their needs. Each resident will be reminded about privacy screens available for the bedrooms, the limited spaces for privacy available in this facility, and how we can best meet their needs. We have updated our privacy policy to include more information provided prior to and at admission about privacy challenges we face in our facility and if this facility is appropriate for them. We are remodeling a room formerly used for the beautician. This will be used for resident private space. It will continue to be used for private phone calls in addition to meeting with visitors. The remodeling has already begun and the room is usable during the remodeling. The project will be completed by the date of the correction.	

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F 164	Continued From page 3	F 164		

On 2/13/15, at 12:47 p.m. the director of nursing pointed to the chair in the front entryway and stated, "I like to keep treatments private. I like to do them right here." The DON also stated,"She [R5] was the resident you saw earlier get the nebulizer treatment right here. A lot of the residents get treatments here--eye drops, foot cream, foot soaks, insulins. Most of the residents receive some kind of treatment now, couple don't." The DON further stated, "That place [entryway] is where we do all the treatments and have always done treatments." The DON reported she had worked as the night nurse for years before taking the DON position last year.

On 2/13/15, at 9:28 a.m. the administrator stated regarding privacy, "In the open we would not be lifting up residents' shirts to give shots or nebulizer treatments. Those things are done in the office, even though there is not so much room in there." The administrator further stated, "Most of the residents don't mind getting their treatments there [in the entry way of the front door main entrance]."

R13's family member (FM)-A was asked on 2/9/15, at 6:57 a.m. during a family interview if there was a place to meet privately in the facility. R13's husband was asked, Can you meet privately with your relative? FM-A replied, "No, just in the living room or outside if it is warm and no one is smoking outside." At the time of the interview there were residents seated either in the living room watching television or in the dining room. Staff and/or residents routinely walked through the area.

R10 reported on 2/9/15, at 7:05 p.m. she had to meet her social worker outside the facility each

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F 164	Continued From page 4	F 164		

week. Because there was no private place to meet in the facility, she had to spend $2.00 for a cup of coffee she could not afford in order to do so. R10's quarterly MDS dated 10/25/14, indicated R10 was cognitively intact with delusions.

R3 stated in an interview on 2/12/15, at 2:32 p.m. "We have lack of space for families visiting and visitors...The building is just so big and we have 20 residents so we go out with our visitors and we go somewhere." R3's annual MDS dated 1/14/15, indicated she was cognitively intact, and noted privacy was "somewhat important" to her.

On 2/11/15, at 2:01 p.m. the social service director (SSD) stated when asked, "We try to accommodate visitors or families the best we can. We try upstairs dayroom...try the dining room...might do outside in summer. If a female visitor then may use a bedroom. We can't use the office." The SSD also stated, "We have talked about taking a wall out of a little room where the telephone is upstairs and extending that area to make a room where a table and a couple of chairs could fit."

On 2/13/15, at 9:45 a.m. the activities director pointed out the small room upstairs with a telephone and stated, "That's the phone room. I think it used to be a treatment room." The room contained two ironing boards, a large bulletin board, two mops, a standing scale, two sinks, a vacuum cleaner, a short cabinet padlocked with counter with telephone, and one chair.

On 2/13/15, at 9:24 a.m. the administrator explained, "We just don't have a large enough room for visitors to meet for privacy. We just have

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F 164	Continued From page 5	F 164		

one room with a telephone. We would need to move stuff out of the room. There are challenges with that...a sink in there." The administrator further stated the telephone room was for privacy and previously housed the beautician. The administrator said the sinks would need to be pulled out and the wall moved. The administrator added, "We are stuck with this building and we can't make one [visiting room] downstairs. It really just affects one family."

During the initial tour on 2/9/14, at 12:14 p.m. only one mobile privacy screen was observed in the multi-resident bedrooms.

R17 reported in an interview on 2/9/14, at 1:15 p.m. "I want privacy by my bed here. I had to ask for a privacy screen." A privacy screen was observed near the head of R17's bed. The screen was approximately about 5 feet high, 3-4 feet wide, was made out of PVC pipe with cloth, and was on wheels. At the time of the observation, the screen partially covered R17, who was seated on her bed. On 2/13/15, at 12:46 p.m. R17 could be partially visualized from the hallway while she laid on her bed. R17's roommate was in the room at the time and the bedroom door was propped open. R17's annual MDS dated 1/2/15, indicated R17's cognition was moderately impaired and privacy was "very important" to the resident.

R10 stated on 2/13/15, at 8:40 a.m. "I do want privacy in my bedroom. I had a privacy screen once, but it kept falling apart, and I had to try to keep putting it back together." R10 also stated, "It [privacy screen] doesn't work."

On 2/13/15, at 9:24 a.m. the administrator stated,

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F 164	Continued From page 6 "She asked for a privacy screen and she got one." The administrator also stated, "We have plenty of privacy screens downstairs. We have at least one. Whoever asks for one will get one or two. Most of the girls [residents] change their clothes in the bathroom anyway." R10's quarterly Minimum Data Set (MDS) indicated she was cognitively intact and was independent with activities of daily living. A resident privacy policy was requested but was not provided by the facility.	F 164		
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 interview and document review the facility's vulnerable adult policy did not include direction for staff to immediately report allegations of abuse, neglect, or misappropriation of property to the State agency (SA). In addition, the policy did not complete reference checks should be completed for pre-screening of potential new employees prior to hiring as required for 2 of 2 newly hired employees registered nurse (RN)-A and Cook-A. Findings include:	F 226	For potential employee reference checks, the surveyor information is incorrect. Our policy does state that applicants will have references checked prior to hiring. All reference checks were also completed. Unfortunately, these were verbal interviews and not documented. The surveyors also told the SSD that this is not a requirement to log them. From SOM Appx PP, dated 02-06-2015, a facility must Screen potential employees for a history of abuse, neglect or mistreating residents as defined by the	3/9/15

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F 226	Continued From page 7 On 2/11/15, at 3:15 p.m. registered nurse (RN)-B stated she was to report any resident to resident altercations to the director of nursing or to the social services director (SSD). She was also to fill out the incident report and the Vulnerable Adult (VA) form and was instructed to give the form to the director of nursing (DON) "right away." The DON was then responsible for reporting online. RN-B said she did not do any online reporting, not was there a computer at the facility. On 2/12/15, at 2:44 p.m. a licensed practical nurse (LPN)-A stated if a "resident assault" occurred she would call the Common Entry Point (CEP--Minnesota reporting system), but did not state she would report to the SA. She would also immediately notify the DON and administrator immediately and fill out an incident report. On 2/10/15, at 11:28 a.m. the SSD stated if there was any kind of resident abuse, it was first immediately reported to the administrator, and then as a team they decided if the incident was reportable. SSD also stated the staff completed a CEP report, and then faxed or called it in. The SSD further stated the online report to the SA would then be completed within 24 hours. On 2/13/15, at 9:00 a.m. the administrator stated regarding the reporting process, "We follow the guidelines from the state. With any resident allegation of abuse we pull out the flow chart and determine what is reportable." The administrator also stated staff knew to call the administrator as soon as possible, and if not available to notify the SSD. The administrator further stated he was the only staff who submitted online reports to the SA (Office of Health Facility Complaints). The administrator stated, "I know it is supposed to be	F 226	applicable requirements at 483.13(c)(1)(ii)(A) and (B). This includes attempting to obtain information from previous employers and/or current employers, and checking with the appropriate licensing boards and registries. We have always met this requirement, although verbal. We will begin documenting those interviews on a form and maintain in the employee file if hired. We have created the form and policy for its use. Our policies and procedures for reporting meet the guidance of this requirement as written. From SOM Appx PP, dated 02-06-2015, ¿483.13(c)(2) 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). Immediately means as soon as possible, but ought not exceed 24 hours after discovery of the incident, in the absence of a shorter State time frame requirement. All staff answered this correctly during surveyor interviews and is also reflected in our reporting policy so there is no correction needed.	

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F 226	Continued From page 8	F 226		

[reported] immediately, as soon as possible, but within 24 hours. I will generally report it in the same evening or the next morning. I understand immediately is not realistic--it's on me to do that." The administrator further stated, "In some cases I report to the SA immediate and in some cases I report to the SA is not so immediate." The administrator said he was the only staff person with computer access and added, "We will have to work on that."

The 6/6/12, Grand Avenue Residence Vulnerable Adult Maltreatment Prevention Plan noted, "Screening Potential employees will be screened for a history of abuse, neglect or mistreatment...." Reporting/Response noted, "If maltreatment is suspected or observed, the Administrator must be notified immediately...The Administrator submits an online report to the Minnesota Department of Health within 24 hours."

On 2/12/15, at 9:05 a.m. a list of newly hired employees' files was requested of the social service director (SSD). Upon reviewing the papers requested for both newly hired RN-A hired 2/11/15, and Cook-A hired 1/07/15, employee reference checks were not found in either employees' papers.

The SSD verified at 9:15 a.m. that reference checks could not be located in the staffs' files. The SSD explained she had called references for the employees over the telephone, but had not written anything down in the employee files. The SSD said she had always completed the references in that manner and had never documented any information learned, but would certainly do so in the future. The SSD reported to the surveyor, "I called for his [Cook-A's]

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F 226	Continued From page 9 references and he checked out beautifully." When asked if any documentation was available regarding the reference check answered, "Just verbally." The Grand Avenue Residence Vulnerable Adult Maltreatment Prevention Plan dated 6/06/2012, indicated under 'Procedures to Prevent Abuse: 1. Screening Potential employees will be screened for a history of abuse, neglect or mistreatment through: A) Completion of criminal background check on all employees and volunteers. Contracted service employee background checks will be acquired and kept on file with employee background check forms.	F 226		
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 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	F 329		4/6/15

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F 329	Continued From page 10 drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility did not ensure psychiatric notes were obtained from the psychiatrist for 1 of 5 residents (R10) reviewed for unnecessary medications. Findings include: R10's use of antipsychotic and anti-anxiety medications did not include a rationale for continued use in the medical record. R10's quarterly Minimum Date Set (MDS) indicated R10's cognition was intact, with delusions. The MDS also indicated R10's active diagnoses included anxiety and schizophrenia (mental illness). On 2/12/15, at 9:55 a.m. the director of nursing (DON) stated R10's psychiatrist did not send progress notes from psychiatric visits, including visits on 10/16/14 and 12/1/14. The DON verified she had not received summary notes for R10's psychiatric visits, nor had she attempted to obtain them. "None of her progress notes for her psychiatric visits are here in the chart. I will call and get them." The DON then requested the notes from R10's clinic. At 10:25 a.m. the DON stated, "It is difficult with her as she makes her own psychiatric appointments and makes her own transportation.	F 329	These two appointments for R10 were for a resident who set up and coordinated appointments on their own. The DON was confused when speaking to the surveyors because the facility did have the documents, and they had been thinned from the chart. We implemented more tracking of the appointments to ensure that the documents come back from an appointment and if the documents did not come back, the process initiates follow up to ensure we receive them. The tracking includes follow up for additional appointments, orders, etc. The DON will spot check appointments weekly and the care team will audit the charts quarterly to ensure that the proper follow through has been completed. This will also be addressed by the QA team quarterly for one year to evaluate the process and make improvements if necessary.	

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F 329	Continued From page 11 After she gets back from her appointment she will tell me she saw her psychiatrist today." The DON stated R10 routinely did not bring any papers back with her from her appointment, unless the facility sent a referral form with the resident. When a referral form was sent with R10, the resident brought back the form with notes. The form had not been competed, as they did not know when the resident was leaving for the psychiatric appointment. The DON stated, "She will tell us when she gets back that she had an appointment, so I suppose the right thing to do is to call the physician and get the progress notes for the visit. I have to call for psychiatric visit notes for her." On 2/12/15, at 2:21 p.m. the DON stated she was able to catch R10 and give her a "blue paper" for the physician to complete as the resident had mentioned to the DON she was on her way out to an appointment. Physician progress notes for R10's visits to her psychiatrist were not provided by the facility.	F 329		
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 per resident in three resident bedrooms (101,102, and 103) affecting eight residents (R1, R2, R4,	F 458	A waiver is requested for rooms 101,102 and 103 because they do not meet the requirements of 80 square feet per resident. We are requesting the waiver	3/5/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	3956 GRAND AVENUE S0UTH MINNEAPOLIS, MN 55409

(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 458	Continued From page 12 R5, R11, R14, R16 and R19) who bedroom had fewer than the required footage. Findings include: 1) Room 101 had three residents residing in the room with 211.33 square feet of floor space. A large wooden wardrobe was built into the room, which measured 13.5 square feet, leaving 197.83 square feet of usable space or 66 square feet for each resident. 2) Room 102 had three residents residing in the room with 232 square feet of floor space or 77.3 feet per resident. 3) Room 103 had two residents residing in the room had 238.26 square feet of floor space. Three wooden wardrobes were built into the room. One wardrobe measured 6 square feet; another measured 5.3 square feet and the third measured 6.25 square feet. That resulted in 220.71 square feet of useable floor space or 73.7 square feet per resident. On 2/11/15, at approximately 3:30 p.m. the residents residing in those rooms were interviewed an all expressed satisfaction with the space provided. On 2/13/15, at 9:00 a.m. the administrator verified the facility was aware of the space requirements, and planned to request a federal waiver regarding the room measurements.	F 458	because: We have operated over 40 years in the same facility. During this time, there have been no adverse effects due to the room sizes. Our residents are generally satisfied. Our resident concerns are minimal. When a resident does have a concern it is generally because they came to our facility from an apartment or home and we cannot accommodate as many of their belongings as they would prefer. We do try to accommodate them to the extent possible. All of our residents are ambulatory. We do not have wheel chairs in the facility and have not encountered any safety or health problems due to the existing room sizes. The residents have the opportunity to decorate their room and put up different personal items of enjoyment. Our residents have ample room for personal possessions. Each resident has a custom-made locking wardrobe cabinet. There is enough room for chairs and other preferred furniture to the extent possible. The beds in our rooms fit the space very well and allow for exit and entry without issue. Nursing has not had any problems providing nursing care.	

GRAND AVENUE REST HOME INC.
3956 Grand Avenue South
Minneapolis, MN 55409
(612) 824-1434

March 5, 2015

Minnesota Department of Health
Licensing and Certification Program
ATTN: Gayle Lantto
P.O. Box 64900
St. Paul, MN 55164-0900

RE: Provider ID 24E150, F-458 Waiver Request, CMS-2567 Survey Completed 02/13/2015

We request a room size waiver for rooms 101, 102 and 103. These rooms are close to the requirement, but do not meet the requirements of 80 square feet per resident.

We are requesting the waiver because:

1. We have operated over 40 years in the same facility. During this time, there have been no adverse effects due to the room sizes. Our residents are generally very satisfied as continually shown in the resident satisfaction surveys. Our resident concerns are minimal. When a resident does have a concern it is generally because they came to our facility from an apartment or home and we cannot accommodate as many of their belongings as they would prefer. We do try to accommodate them to the extent possible.

2. All of our residents are ambulatory. We do not have wheel chairs in the facility.

3. We have not encountered any safety or health problems due to the existing room sizes.

4. The residents have the opportunity to decorate their room and put up different personal items of enjoyment.

5. Our residents have ample room for personal possessions. Each resident has a large wardrobe cabinet which is part of the reason for the reduced room size.

6. There is enough room for chairs and other preferred furniture to the extent possible.

7. The beds in our rooms fit the space very well and provide room for entry and exit without issue.

8. Nursing has not had any problems providing care.

This has been an approved ongoing waiver for many years.

Sincerely,

Allen Soderbeck
Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/13/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	**3956 GRAND AVENUE S0UTH** **MINNEAPOLIS, MN 55409**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Grand Avenue Rest Home 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 Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/04/2015

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
	24E150	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/13/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	**3956 GRAND AVENUE S0UTH** **MINNEAPOLIS, MN 55409**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 2-story building was determined to be of Type V(000) construction. It has a basement and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to corridors which is monitored for automatic fire department notification. The facility has a capacity of 20 beds and had a census of 20 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 This STANDARD is not met as evidenced by: Based on observation and interview, this building does not meet the requirements for construction	K 012	This facility conducts an annual FSES and achieved a passing FSES score.	2/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/13/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	**3956 GRAND AVENUE S0UTH** **MINNEAPOLIS, MN 55409**

(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 012	Continued From page 2 type and height. This deficient practice could affect all residents. Findings include: During a tour of the facility between 9:30 AM and 10:30 AM on 02/13/2015, observation revealed that this 1903, 2-story, fully fire sprinklered building of Type V(000) construction does not meet the minimum construction requirements of the code for type and height. This deficient practice was verified by the administrator 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 032 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: Based on observation and interview, two approved remote exits are not provided from the second floor. This deficient practice could affect all residents. Findings include:	K 032	This facility conducts an annual FSES and achieved a passing FSES score.	2/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/13/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	**3956 GRAND AVENUE S0UTH** **MINNEAPOLIS, MN 55409**

(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 032	Continued From page 3 During a tour of the facility between 9:30 AM and 10:30 AM on 02/13/2015, observation revealed that the outside fire escape stairs do not provide the required two (2) remote exits from the second floor. This deficient practice was verified by the administrator 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 032		
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 This STANDARD is not met as evidenced by: Based on observation and interview, the stairway enclosure of this facility does not meet the required one (1) hour fire resistive construction. This deficient practice could affect all residents. Findings include: During a tour of the facility between 9:30 AM and 10:30 AM on 02/13/2015, observation revealed that wall construction of the stair enclosure is constructed of plaster on wood lath on wood	K 033	This facility conducts an annual FSES and achieved a passing FSES score.	2/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/13/2015**

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K 033	Continued From page 4 studs, which does not meet the one (1) hour fire resistive construction requirements for this type of facility. This deficient practice was verified by the administrator 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 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 9:30 AM and 10:30 AM on 02/13/2015, observation revealed that the second floor corridor is only 39 inches in clear width and not the 48 inches required for this type of facility. This deficient practice was verified by the administrator at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall	K 039	This facility conducts an annual FSES and achieved a passing FSES score.	2/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/13/2015**

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K 039	Continued From page 5 level of fire safety equivalent to that required by the Life Safety Code.	K 039		

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Tuesday, February 17, 2015 2:19 PM
To: rochi_lsc@cms.hhs.gov
Cc: robert.rexeisen@state.mn.us; 'allen.soderbeck@gmail.com'; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); marian.whitney@state.mn.us; Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject: Grand Avenue Rest home (24E150) 2015 Annual FSES - Previously Approved - No Changes

This is to inform you that I am accepting the FSES inspection report that was conducted on 2-13-15. The exit date was 2-13-15.

I am recommending that CMS approve this report.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

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

FE150023

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 GRAND AVENUE REST HOME	BUILDING 01-MAIN BUILDING
ZONE(S) EVALUATED BASEMENT	
PROVIDER/VENDOR NO. 24E150	DATE OF SURVEY 02/13/2015

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	1.6	X	☐	X	☐	=	1.60

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	1.60	=	1

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

SURVEYOR SIGNATURE ROBERT REXEISEN		TITLE DEPUTY STATE FIRE MARSHAL	DATE 02/13/2015
FIRE AUTHORITY SIGNATURE		TITLE FIRE SAFETY SUPERVISOR	DATE 2-17-15

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			-7
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: -5(0)[f]	Class B: 0(3)[f]	Class A: 3 ✓					3
3. Interior Finish (Rooms)	Class C: -3(1)[f]	Class B: 1(3)[f]	Class A: 3 ✓					3
4. Corridor Partitions/Walls	None or Incomplete: -10(0)[a]	<½ hour: 0	≥½ to <1 hour: 1(0)[a] ✓	≥1 hour: 2(0)[a]				1
5. Doors to Corridor	No Door: -10	<20 min FPR: 0	≥20 min FPR: 1(0)[d]	≥20 min FPR and Auto Clos.: 2(0)[d] ✓				2
6. Zone Dimensions	Dead End: >100 ft: -6(0)[b]	Dead End: >50 ft to 100 ft: -4(0)[b] ✓	Dead End: 30 ft to 50 ft: -2(0)[b]	No Dead Ends >30 ft and Zone Length Is: >150 ft: -2(0)[c]	100 ft to 150 ft: 0	<100 ft: 1		0
7. Vertical Openings	Open 4 or More Floors: -14	Open 2 or 3 Floors: -10	Enclosed with Indicated Fire Resist. <1 hr: 0 ✓	≥1 hr to <2 hr: 2(0)[e]	≥2 hr: 3(0)[e]			0
8. Hazardous Areas	Double Deficiency: In Zone: -11	Double Deficiency: Outside Zone: -5	Single Deficiency: In Zone: -6	Single Deficiency: In Adjacent Zone: -2	No Deficiencies: 0 ✓			0
9. Smoke Control	No Control: -5(0)[c] ✓	Smoke Barrier Serves Zone: 0	Mech. Assisted Systems by Zone: 3					0
10. Emergency Movement Routes	<2 Routes: -8 ✓	Multiple Routes: Deficient: -2	W/O Horizontal Exit(s): 0	Horizontal Exit(s): 1	Direct Exit(s): 5			-8
11. Manual Fire Alarm	No Manual Fire Alarm: -4	Manual Fire Alarm: W/O F.D. Conn.: 1	W/F.D. Conn: 2 ✓					2
12. Smoke Detection and Alarm	None: 0(3)[g] ✓	Corridor Only: 2(3)[g]	Rooms Only: 3(3)[g]	Corridor and Habit. Spaces: 4	Total Spaces In Zone: 5			3
13. Automatic Sprinklers	None: 0	Corridor and Habit. Space: 8	Entire Building: 10 ✓					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.

[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.

For SI units: 1 ft = 0.3048 m

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

FE150023

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
GRAND AVENUE REST HOME	01-MAIN BUILDING

ZONE(S) EVALUATED: FIRST FLOOR

PROVIDER/VENDOR NO.	DATE OF SURVEY
24E150	02/13/2015

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	1.6	X	15	X	1.1	X	4.0	X	1.2	=	12.70

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	12.70	=	8

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

SURVEYOR SIGNATURE ROBERT REXEISEN		TITLE DEPUTY STATE FIRE MARSHAL	DATE 02/13/2015
FIRE AUTHORITY SIGNATURE		TITLE FIRE SAFETY SUPERVISOR	DATE 2-17-15

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			-2
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					3
	-5(0)[f]	0(3)[f]	3 ✓					
3. Interior Finish (Rooms)	Class C	Class B	Class A					1
	-3(1)[f]	1(3)[f] ✓	3					
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	≥½ to <1 hour	≥1 hour				0
	-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.				0
	-10	0 ✓	1(0)[d]	2(0)[d]				
6. Zone Dimensions	Dead End			No Dead Ends >30 ft and Zone Length Is				1
	>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.					0
	-14	-10	<1 hr	≥1 hr to <2 hr	≥2 hr			
			0 ✓	2(0)[e]	3(0)[e]			
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies			0
	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					0
	-5(0)[c] ✓	0	3					
10. Emergency Movement Routes	<2 Routes	Multiple Routes						-8
		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						2
		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			3
	0(3)[g]	2(3)[g] ✓	3(3)[g]	4	5			
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building					10
	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.

[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.

For SI units: 1 ft = 0.3048 m

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)	1			1
4. Corridor Partitions/Walls	0			0
5. Doors to Corridor	0		0	0
6. Zone Dimensions			1	1
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			-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= 13	S_3= 4	S_4= 10

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 5	=	C 7	✓	
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 10	−	R 8	=	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.

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

FE150023

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
GRAND AVENUE REST HOME	01-MAIN BUILDING

ZONE(S) EVALUATED: SECOND FLOOR

PROVIDER/VENDOR NO.	DATE OF SURVEY
24E150	02/13/2015

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	1.2	X	4.0	X	1.2	=	8.60

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	8.60	=	6

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

SURVEYOR SIGNATURE ROBERT REXEISEN		TITLE DEPUTY STATE FIRE MARSHAL	DATE 02/13/2015
FIRE AUTHORITY SIGNATURE		TITLE FIRE SAFETY SUPERVISOR	DATE 2-17-15

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			-7
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					3
	-5(0)[f]	0(3)[f]	3 ✓					
3. Interior Finish (Rooms)	Class C	Class B	Class A					3
	-3(1)[f]	1(3)[f]	3 ✓					
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	≥½ to <1 hour	≥1 hour				0
	-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.				0
	-10	0 ✓	1(0)[d]	2(0)[d]				
6. Zone Dimensions	Dead End			No Dead Ends >30 ft and Zone Length Is				0
	>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.					0
			<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			0
	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					0
	-5(0)[c] ✓	0	3					
10. Emergency Movement Routes	<2 Routes	Multiple Routes						-8
		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						2
		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			3
	0(3)[g]	2(3)[g] ✓	3(3)[g]	4	5			
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building					10
	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.

[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.

For SI units: 1 ft = 0.3048 m

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	0		0	0
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= 9	S_2= 8	S_3= 3	S_4= 6

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 9	−	S_a 9	=	C 0	✓	
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 3	−	S_c 3	=	P 0	✓	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 6	−	R 6	=	G 0	✓	

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.