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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7UKT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00780

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/22/2013** (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)
06/30

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

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Unit Supervisor 03/26/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 03/26/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS
Posted 4/9/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/22/2013
(L33)

DETERMINATION APPROVAL

CCN# 24E507

At the time of the standard survey completed February 7, 2013, the facility was not in substantial compliance and the most serious deficiencies were found 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 are required. The facility was given an opportunity to correct before remedies were imposed.

On March 22, 2013, the Minnesota Department of Health and, on March 8, 2013, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) by review of the plan of correction and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on February 7, 2013, effective March 11, 2013. Therefore, the remedies outlined in our letter dated February 19, 2013, will not be imposed.

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

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

See attached CMS-2567B forms for the results of the March 22, 2013 and March 8, 2013 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN# 24E507

March 26, 2013

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

Dear Mr. Anderson:

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

Based upon your facility being in substantial compliance, we are recommending to the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective March 11, 2013 the above facility is certified for:

17 Nursing Facility II Beds

Your facility's Medicare approved area consists of all 17 nursing facility beds.

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

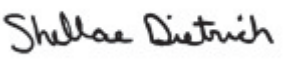
If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicaid Program.

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 Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,



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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 26, 2013

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

RE: Project Number SE507022

Dear Mr. Anderson:

On February 19, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 7, 2013. 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 March 22, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 8, 2013 the Minnesota Department of Public Safety completed a PCR by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 6, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 11, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 6, 2013, effective March 11, 2013 and therefore remedies outlined in our letter to you dated February 19, 2013, will not be imposed.

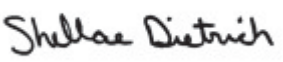
Your request for continuing waivers involving the deficiencies cited under F354 and F458 at the time of the February 7, 2013 standard survey has been approved.

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

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

Feel free to contact me if you have questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5070r113.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E507	A. Building B. Wing	3/22/2013

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **03/01/2013**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/11/2013**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **03/04/2013**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **03/01/2013**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **03/05/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/sd	03/26/13	28120	03/22/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/6/2013			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E507	A. Building B. Wing **01 - MAIN BUILDING 01**	3/8/2013

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **02/27/2013**	ID Prefix	Correction Completed **02/27/2013**	ID Prefix	Correction Completed **02/27/2013**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0012		LSC K0033		LSC K0034	
ID Prefix	Correction Completed **02/27/2013**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/sd	03/26/13	28120	03/08/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/7/2013

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: 7UKT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00780

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E507**

2.STATE VENDOR OR MEDICAID NO.
(L2) **904343800**

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

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/06/2013** (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)
06/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Becky Wong, HFE NE II 03/09/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 03/21/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS
Posted 3/22/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN# 24E507

At the time of the standard survey completed February 7, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

The facility's request for waivers of the following requirements have been approved:

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

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 7UKT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00780

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/06/2013** (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)
06/30

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

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

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

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

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

And/Or Approved Waivers Of The Following Requirements:
___2. Technical Personnel
___3. 24 Hour RN
X 4. 7-Day RN (Rural SNF)
___5. Life Safety Code
___6. Scope of Services Limit
___7. Medical Director
X 8. Patient Room Size
___9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Becky Wong, HFE NE II — 03/09/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Shellae Dietrich, Program Specialist — 03/21/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
3-22-13 (L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions) 020499

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 6119

February 19, 2013

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

RE: Project Number SE507022

Dear Mr. Anderson:

On February 7, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

Telephone: (651) 201-3792

Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 18, 2013, 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 18, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 6, 2013 (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 6, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

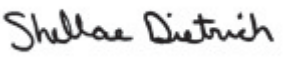
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File E507s13.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	02/06/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE 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	RECEIVED MAR 05 2013 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to have the prior survey results accessible to the public/residents of the facility. That had the potential to affect all 17 residents and the visitors of the facility.	F 167	A copy of the annual MDH Survey with the results will now be posted near the Nursing desk on the wall. The document will be clearly labeled. Program Director to monitor.	3/1/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark J. Anderson | TITLE: Administrator | (X6) DATE: 3/4/13

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	02/06/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 167	Continued From page 1 Findings include: A memo was observed posted on the information board that directed residents and visitors to request a copy of the prior survey from the program manager (PM). On 2/5/13, at 9:00 a.m. when the PM was asked where the last survey results were posted, the PM produced the survey from a three-ring binder at his desk. The binder contained the 2012 and 2011 survey results, other folders and documents. The 2012 survey results were stapled together. The results of the survey were not readily accessible to visitors and residents.	F 167		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	A Vulnerable Adult Abuse prevention 'problem' will be added to all residents' Care Plans. The Abuse Checklist form was reviewed and utilized for each resident, when new interventions added. Existing Care Plan problems/interventions that relate to possible abuse vulnerabilities have also been marked with 'red stars' to further note existing interventions. The Program Director and D.O.N. are completing collaboratively. All Nursing staff will be educated on these new interventions. D.O.N. to monitor.	3/11/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	02/06/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 2	F 279		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to develop comprehensive care plans for 3 of 5 residents reviewed for behaviors identified by the facility on the Individual Abuse Prevention Plan Susceptibility to Abuse Checklist (R17, R4, R14).

Findings include:

R17 was admitted 11/27/12, with diagnoses of paranoid schizophrenia, post-traumatic stress disorder (PTSD), psychotic disorder (other than schizophrenia) depression, anxiety, and adult failure to thrive. Received antidepressant medication of citalopram 30 milligrams (mg) daily for depression, and antipsychotic medication of Risperidone 4 mg tablet at bedtime for psychosis.

On 2/4/13, at 2:55 p.m. R17 stated that loud noises frighten her, and she was afraid at the facility when the other residents are loud.

A psychiatric consult note dated 10/18/12, indicated R17 "hears noises very loudly, sensitive to noises. and those cause anxiety, she was in a Bosnian concentration camp and was likely abused there PTSD, has nightmares and anxiety over safety. Survivor of torture, symptoms of anxiety and PTSD, Cachetic appearing (physical wasting with loss of weight and muscle mass), poor insight, poor judgment, oriented to person."

A care plan dated 12/3/12, indicated "impaired cognition and a self-care deficit, related to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	02/06/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 3	F 279		

psychosis, with psychotic features of: anxiety, PTSD, Incoherence, delusions, hallucinations, catatonic or disorganized behaviors, confusion, eating disorder, insomnia, poor concentration, nightmares, hypervigilance and being easily startled). A history of disordered eating, including eating leaves from the ground. Impaired communication related to use of broken English, tendency to isolate in her room, and belief that she would be better off dead. A safety concern of the potential to get lost if outside alone (known to be walking back and forth on the sidewalk)." The activity care plan indicated R17 would be invited to all group activities and be encouraged in independent activities.

An Individual Abuse Prevention Plan Susceptibility to Abuse Checklist dated 12/8/12, indicated R17 was identified at risk of abuse related to expressed suicidal thoughts or actions (stated may be better off dead), exhibiting psychotic behavior such as delusions, and easily exploited by others.

A Behavior Sheet dated 2/1/13, indicated: "resists cares, self-injurious, delusion, wanders without purpose, overly passive or withdrawn, isolates self in room, non-redirectable." Resident "has mistaken belief that she can miss taking antipsychotic medications for up to 2 days, resident did not believe missing these medications will harm her mental well-being, resident continues to isolate in her room."

At 11:00 a.m. on 2/5/13, the program manager (PM) was not aware that R17 felt afraid; stated R17 had not informed him during 1:1, and he would consider a room change to put her with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	02/06/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 4 quieter residents on the 2nd floor. R17's care plan 12/3/12, lacked problems, goals and clear interventions to minimize the identified behaviors the facility assessed on the Individual Abuse Prevention Plan Susceptibility to Abuse Checklist of being easily exploited by others, identify if the resident would be able to remove herself from a dangerous/loud situation and lacked interventions for how R17 would be protected from exploitation, or if R17 should be accompanied when outside. R4 was admitted with diagnosis of schizoaffective disorder, Diabetes mellitus, polysubstance abuse, medication noncompliance, alteration of mood/thoughts. Receives bi-polar medication, Abilify 5 mg every day, lithium 600 mg twice a day. Antipsychotic medication Risperidone 3 mg twice a day. Antianxiety medication Lorazepam 1 mg every evening and twice daily as needed. At 11:40 a.m. on 2/4/13, R4 was observed in the dining room, loudly calling out the PM's name repeatedly to get his attention, while he ushered the survey team to the work area. At 4:40 p.m. on 2/4/13, R4 loudly and repeatedly called the PM's name to give her cigarettes. At 10:04 a.m. on 2/5/13, R4 repeatedly called across the room to have the PM assign someone to clip her toenails. A care plan dated 8/14/12, indicated, "paranoid delusions, and decreased sleep related to noncompliance with medications. Cognition diagnosis schizoaffective disorder bipolar type, personality disorder polysubstance abuse, behaviors, impaired decision making, verbal and physical abuse to others. Goal: resident will show	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	02/06/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 5	F 279		

no abuse, demonstrate orientation, show increased ability in decision making, demonstrate socially appropriate behavior in next 3 months. Take medications as ordered, re-orient to reality when needed, monitor, document and notify MD of increased disorientation and decompensation, daily cues and supervision of decision making, encourage participation in activities, encourage R4 to avoid substance abuse, warn residents of the dangers of smoking in the house." The care plan did address safety, indicating give directions and lead resident to safety in an emergency.

An Individual Abuse Prevention Plan Susceptibility to Abuse Checklist dated 11/13/12, indicated behavioral symptoms of: "assaultive , combative and abusive to others. Verbally threatening to others, displaying rage, had poor impulse control, or was unable to express anger appropriately. Wandering into other residents rooms, rummaging through their drawers, or taking other residents belongings. Exhibiting personal habit patterns which are offensive or antisocial such as poor personal hygiene, offensive odor or nudity. Exhibiting psychotic behavior such as hallucinations or delusion."

At 1:30 p.m. on 2/6/13, the PM stated "that's just her (R4), she can't wait for anything, it all needs to be right now on her time."

R4's care plan lacked problems, goals and clear interventions to minimize the identified behaviors the facility assessed on the Individual Abuse Prevention Plan Susceptibility to Abuse Checklist, when the resident was assaultive, combative or abusive to others; verbally threatening,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	02/06/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 6 threatening others with her cane, repetitive or perseverate with loud vocalizations or rummaged through and took others belongings. R14 was admitted with diagnoses of depression, anxiety, mood disorder, psychosis, substance abuse, alcohol dependence, musculoskeletal pain, major depression with psychotic symptoms, psychotic mood disorder, adult failure to thrive. R14 received an anti-psychotic medication Seroquel 30 mg every evening. Anti-depressant medication Paxil 40 mg every day. Anti-anxiety medication Hydroxyzine 50 mg twice a day. Insomnia medication Ambien 5mg at bedtime everyday and 5 mg every bedtime as needed for sleep. Care Plan updated 7/18/12, indicated, "Cognitive impairment related to depression, anxiety, panic attacks, insomnia, psychosis, delusions, disorderly mood, verbally threatening, non-compliance with medications/treatments, use of illegal substances, orientation, recall decision making, interpersonal relationships. Potential for altered health maintenance related to underweight, history of pancreatitis, and marijuana smoking. Self-care deficit related to depression and anxiety, keeps food in room, reluctant to shower, poor oral care. activities with group and independent, congestive heart failure resulting in shortness of breath and chest pain." The Individual Abuse Prevention Plan Susceptibility to Abuse Checklist dated 1/18/13, indicated the facility assessed R14 at risk for "verbally threatening to others, displaying rage or has poor impulse control, or was unable to	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	02/06/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 7 express anger appropriately. Exhibiting self -injurious behaviors or self-inflicted abuse, wandering into other residents rooms, rummaging through their drawers, or taking other residents belongings. Exhibiting personal habit patterns which are offensive or antisocial, such as poor personal hygiene, offensive odor or nudity, exhibiting psychotic behavior such as hallucinations." The care plan lacked problems, goals and interventions to minimize the identified behaviors on the Individual Abuse Prevention Plan Susceptibility to Abuse Checklist identified by the facility at risk of wandering, rummaging in and taking others belongings and exhibiting psychotic behavior such as hallucinations and delusions. At 2:03 p.m. on 2/6/13, the director of nursing (DON) was interviewed and verified that the Individual Abuse Prevention Plan Susceptibility to Abuse Checklist was an assessment tool and did not identify goals or provide interventions to the risk of abuse identified by the facility checklist. At 2:09 p.m. on 2/8/13, the activities coordinator stated R17 was a private person, and spends most of the time in her room, "I do jigsaw puzzles with her, she may get up and leave and then come back later". I have taken her out to shop at K-mart and have asked her to go shopping many times, but she refuses to go out more than half the time, because she was such a private person. I have taken her for walks around the block, she used to do that a lot when she first came here. I have taken her for drives and she recognized a school she used to attend.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	02/06/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 8 At 2:15 p.m. on 2/8/13, the PM stated that R17 used to be accompanied for all doctors appointments by transportation and staff members. But her most recent appointment she stated she could go by herself and she did go by herself and successfully come back alone. A Southside Care Center Care Plans policy (undated) indicated: 2. A full scale nursing assessment is done within seven days after admission, with the nursing assessment form being completed at that time. 4. The assessment is then done annually in conjunction with the annual Care Conference. 6. The integrated Care Plan will include resident care concern with measurable and specific goals.	F 279		
F 354 SS=C	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on resident condition, staff interview and facility schedules the facility failed to employ a RN	F 354	Waiver Requested (see attached addendum). Administrator to monitor.	3/4/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	02/06/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 354	Continued From page 9	F 354		

(registered nurse) on a full time basis, for eight consecutive hours, seven days per week. This had the potential to effect all 17 residents in the facility.

Findings include:

The facility had a waiver for 24 hour licensed nurse coverage and eight hour RN coverage, dated 3/12/12. According to the waiver, all 17 residents were ambulatory and capable of self-preservation.

The waiver stated the RN provided 15 hours of coverage a week and on-call.

A licensed practical nurse (LPN) was in the facility 16 hours a day, a trained medication aide (TMA) was in the facility during the night shift hours. An interim DON worked 15 hours per week and performed the required assessments.

On 2/12/13, at 2:40 p.m. the program manager (PM) stated the RN worked approximately nine to 12 hours week. The PM also indicated the facility had been advertising for a RN and an offer had been extended to a RN.

On 2/13/13, at 2:45 p.m. the interim DON was interviewed and indicated she worked 10 hours a week and was on-call 24 hours day/seven days a week.

Advertisements for RN Consultant in a large dialy newspaper were dated 11/22/12 and 12/2/12

F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356	The Nurse Staffing form has been updated to include resident census and nurse staff totals for each shift. This informational form will continue to be posted daily near the Nursing Desk. Administrator will monitor.	3/4/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	02/06/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 10 The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to have the required elements on the nurse staff posting. That had the potential to affect all 17 residents and the visitors of the facility.	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	02/06/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 11 Findings include: On initial facility tour 2/4/13, at 11:45 a.m. the posted nurse staffing contained licensed practical nurse (LPN) shifts, and numbers written into the shifts as follows: - 7 to 3 LPN 16 hours, - 3 to11 LPN eight hours, - 11 to 7 trained medication aide (TMA) eight hours. The staff posting lacked the required facility census at the start of each shift, and the total number and actual hours worked by category of staff providing care. On 1/30/13, at 10:30 a.m. the program manager was interviewed and acknowledged the staff posting contained incorrect information.	F 356		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility did not store food under sanitary conditions in 4 of 4 refrigerators. That	F 371	The two freezers and two refrigerators were cleaned and sanitized. These four units in the storeroom have been added to the revised Kitchen Cleaning Schedule. The schedule now includes suggested frequencies for each cleaning task. Food Service staff will follow this schedule and track cleaning of all the equipment on a regular basis. Program Director to monitor.	3/1/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	02/06/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 12 had the potential to affect all 17 residents in the facility. Findings include: The initial kitchen tour was conducted on 2/4/13, at 12:00 p.m. The food storage room was observed and all four refrigerators were soiled with brown and black marks on the outside door where a hand would touch the surface to open the door. The bread refrigerator was soiled with food debris on the bottom of the interior. The horizontal strip between the freezer and refrigerator of the egg refrigerator had multiple black specks. When interviewed on 2/6/13, at 8:49 a.m. Cook-B agreed the four food storage refrigerators were soiled. Cook-B also confirmed the bread refrigerator was soiled on the inside bottom. Cook-B visualized the eggs refrigerator and discussed the multiple black spots. Cook-B agreed the areas would need to be sanitized and proceeded to do so. Cook-B also said the refrigerators were on a routine schedule to be cleaned on a weekly basis. The kitchen cleaning schedule for January 2013 was obtained and only listed the one kitchen refrigerator upstairs. The four basement refrigerators were not included on the cleaning schedule. The facility policy titled, Food Service-Infection Control dated 4/1/10, indicated that foods need to be stored in a clean area.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431	The facility policy- 'Medication Administration' was revised to reflect a proper procedure for storage, the return of medications to the Pharmacy and also the disposal of unused medications. The Program Director and other Nursing employees have been educated on this revised Policy & Procedure. D.O.N. will monitor.	3/5/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	02/06/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 13 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	02/06/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 14 review, the facility did not store medications securely. That had the potential to affect all 16/17 residents in the facility. Findings include: Unlicensed staff and two residents were observed to enter an area where medications were not secured. Observation of the food storage area in the basement of the facility on 2/4/13, at 12:00 p.m. revealed there were unsecured medications in the refrigerator door of the egg refrigerator and the milk refrigerator. The egg refrigerator contained the following medications in the door of the refrigerator: Risperdal Consta (an antipsychotic medication) syringes, Novolog insulin (a medication used to treat diabetes) pens, Lantus insulin (a medication used to treat diabetes) pens, and Humalin insulin (a medication used to treat diabetes) vials. The milk refrigerator contained an insulin pen in the door. There was a wire cage door to the food storage area with a pad lock for locking; however, the door was wide open and the lock was not utilized, from 11:30 a.m. to 2:30 p.m. on 2/4/13. - On 2/4/13, at 12:00 p.m. (R11) came down to the basement to ask the program manager (PM) for a PRN (as needed) medication. - On 2/4/13, at 1:18 p.m. staff member B entered the food storage area and then went to the laundry room. - On 2/5/13, at 1:20 p.m. R11 came down to the basement area and went to the laundry area. - On 2/4/13, at 2:30 p.m. cook-A locked the food storage area and left for the day.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	02/06/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 15 - On 2/4/13, at 4:56 p.m. R3 came down to the basement looking for the PM. When interviewed on 2/4/13, at 12:55 p.m. cook-A said they typically leave the food storage room unlocked throughout the day because he comes down to get needed supplies for cooking about ten times per day. Observation revealed cook-A did come down to get food four times between 11:30 a.m. and 2:00 p.m. on 2/4/13. Interview with the PM was conducted on 2/4/13, at 3:00 p.m. during the medication storage review. The PM said the refrigerated medications are double locked in the upstairs kitchen refrigerator. When asked if there were any other medications stored in the facility, he stated, " No. " The surveyor then mentioned that there was several medication observed unsecured in two refrigerators in the basement. The PM stated that these were medications for return and pharmacy was supposed to pick them up but never did. He confirmed they should be secured with a lock and proceeded to relocate the unsecured medications to a secured area. The facility policy titled, Medication Administration, undated indicated medicine was to be locked at all times when not in use.	F 431		
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	F 458	Waiver Requested (see attached addendum). Administrator to monitor.	3/4/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	02/06/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 458	Continued From page 16	F 458		

by:
Based on observation and interview, the facility failed to provide at least 80 square feet of usable space in 1 of 6 resident bedrooms (Room 102) which affected 4 of 17 residents (R4, R7, R12, R13).

Findings include:

On the evening of 2/4/13, the day of 2/5/2013, and the morning of 2/6/2013, four residents were observed to reside in room 102. The useable floor space of that room was 310 square feet which provided 77.5 square feet per resident.

Four residents were observed to reside in room 102. The useable floor space of that room was 310 square feet which provided 77.5 square feet per resident.

The room provided a closet, call device and reading light for each resident in room 102.

During the survey from 2/4/13 through 2/6/13, the residents of room 102 stated they liked their room and there was adequate room for them to keep their personal belongings (R4, R7, R12, R13).

Southside Care Center
2644 Aldrich Ave. South
Minneapolis, MN. 55408
612-872-4233

To: Gloria Derfus

From: Mark J. Anderson MJA
Administrator

RE: Addendum to Plan of Correction
Tag F 468

February 28, 2013

Room Size Waiver Request-F458

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

Southside Care Center
2644 Aldrich Ave. South
Minneapolis, MN. 55408
612-872-4233

To: Gloria Derfus

From: Mark J. Anderson MJA
Administrator

RE: Addendum to Plan of Correction
Tag F 354

March 4, 2013

Staffing Waiver Request for 1) full-time D.O.N., 2) 24 -hour licensed nurse coverage and 3) R.N. day coverage.

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

Adequate and continuity of care is maintained for all residents by the long term staff of the facility who can be reached by phone –Medical Director, Program Director, director of Nursing and Administrator.

The two-week nursing staffing schedule includes:

Day shift 7-3 LPN coverage 14 days

P.M. shift LPN coverage 12 days and TMA coverage 2 days

Night Shift LPN coverage 10 days and TMA coverage 2 days

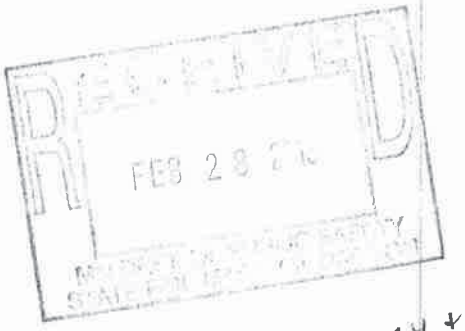
Director of Nursing 10 hours per week and on-call
Administrator 5 hours per week and on-call

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

Please contact me if you have any questions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/07/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, SOUTHSIDE CARE CENTER was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	 POC ok w/FSES for K13, K38, K34 + K39 PB 3-4-13	

DC: 03.18.2013

EXIT: 02.08.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	2/27/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/07/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Barbara.Lundberg@state.mn.us and 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. SOUTHSIDE CARE CENTER is a 2-story building with a full basement. The building was constructed 1909 and was determined to be of Type V(000) construction. This building is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 17 beds and had a census of 17 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1	K 012	Correction not needed. Southside Care Center has achieved a passing FSES score (see enclosed FSES/HC).	2/27/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/07/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 012	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation, this building does not meet the requirement for construction type and height. This deficient practice could affect all residents. Findings include: On facility tour between 9:30 AM and 11:00 AM on 02/07/2013, observation revealed that this 2-story, wood frame facility of Type V(000) construction does not meet the minimum construction requirements for a building of this height. This deficient practice was verified by the manager at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 012		
K 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:	K 033	Correction not needed. Southside Care Center has achieved a passing FSES score (see enclosed FSES/HC).	2/27/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/07/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 033	Continued From page 3 Based on observation, the stairway enclosure of this facility does not meet the required one (1) hour fire resistive construction. This deficient practice could affect all residents. Findings include: On facility tour between 9:30 AM and 11:00 AM on 02/07/2013, observation revealed that the wall of the stair enclosures are constructed of plaster on wood lath on wood studs, which does not meet minimum the requirements for this type of facility. This deficient practice was verified by the manager at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 033		
K 034 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the stairwells in accordance with LSC (2000) Chapter 7.2. This deficient practice could affect all residents. Findings include: On facility tour between 9:30 AM and 11:00 AM	K 034	Correction not needed. Southside Care Center has achieved a passing FSES score (see enclosed FSES/HC).	2/27/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/07/2013

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

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

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Monday, March 04, 2013 4:37 PM
To: 'rochi_lsc@cms.hhs.gov'
Cc: Rexeisen, Robert (DPS); 'mjainmn@comcast.net'; RImholteFiresafe@aol.com; 'Colleen Leach'; 'Jim Loveland'; 'Mark Meath'; 'Mary Henderson'; 'Shellae Dietrich'; Steege, Nicole (MDH); Whitney, Marian (DPS)
Subject: Southside Care Center (24E507) 2013 FSES Report

This is to inform you that I am accepting the 2013 FSES report conducted at Southside Care Center on 2-13-13. The exit date was 2-6-13.

I am recommending the CMS approve this FSES 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

Report of Consultant FSES Findings

Southside Care Center

2644 Aldrich Avenue South

Minneapolis, MN 55408

Provider No. 24E507

Date of Survey: February 13, 2013

Prepared by:
Robert L. Imholte, President
Fire Safety Resources, LLC
16768 County Road 160
Cold Spring, MN 56320
320-685-8559
RImholteFiresafe@aol.com

Fire Safety Resources, LLC
Consulting, Education & Inspection Services

16768 County Road 160
Cold Spring, MN 56320
(320) 685-8559
E-mail: RImholteFiresafe@aol.com

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

February 14, 2013

RE: FSES at Southside Care Center

Dear Mr. Anderson:

Enclosed please find the survey information relating to the fire safety evaluation of Southside Care Center, 2644 Aldrich Avenue South in Minneapolis conducted on 02/13/13. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(01), *Guide to Alternative Approaches to Life Safety*.

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

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

The following factors served as the basis for this evaluation:

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

Based on the conditions found during the 02/13/13 FSES survey, all four parameters in Table 7 of the FSES worksheets, ZONE FIRE SAFETY EQUIVALENCY EVALUATION, in all three zones evaluated were found to have a score of zero or greater. *Fire Safety Resources* finds, therefore, that Southside Care Center has achieved a passing FSES score. Should you have any questions or need additional information, please don't hesitate to get back to me.

Wishing you a safe day!

Robert L. Imholte, President
Fire Safety Resources, LLC

Enclosures
RLI/rli

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

Form Approved
OMB No. 0938-0242

ZONE 3 OF 3 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
Southside Care Center	01-Main Building
ZONE(S) EVALUATED: Second Floor	
PROVIDER/VENDOR NO.: 24E507	DATE OF SURVEY: 02/13/13

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

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

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

TABLE 3A. (NEW BUILDINGS)

F		R
1.0 X	[ ]	= [ ]

TABLE 3B. (EXISTING BUILDINGS)

F		R
0.6 X	6.9	= 4.1 = 5

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

SURVEYOR SIGNATURE: Robert S. Smith — Fire Safety Resources, LLC	TITLE: President	DATE: 02/14/13
FIRE AUTHORITY SIGNATURE	TITLE: Fire Safety Supervisor / State Fire Marshal	DATE: 3-4-13

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

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

TABLE 4.

Safety Parameters	Safety Parameters Values						
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II		
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433
First	-2	0	-2	0	0	2	2
Second	(-7)	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4
2. Interior Finish (Corridors and Exits)	Class C		Class B		Class A		
	-5(0)[f]		0(3)[f]		(3)		
3. Interior Finish (Rooms)	Class C		Class B		Class A		
	-3(1)[f]		1(3)[f]		(3)		
4. Corridor Partitions/Walls	None or Incomplete		<½ hour		≥½ to <1 hour	≥1 hour	
	-10(0)[a]		(0)		1(0)[a]	2(0)[a]	
5. Doors to Corridor	No Door		<20 min FPR		≥20 min FPR	≥20 min FPR and Auto Clos.	
	-10		0		(10)[d]	2(0)[d]	
6. Zone Dimensions	Dead End				No Dead Ends >30 ft and Zone Length Is		
	>100 ft	>50 ft to 100 ft	30 ft to 50 ft		>150 ft	100 ft to 150 ft	<100 ft
	-6(0)[b]	-4(0)[b]	-2(0)[b]		-2(0)[c]	0	1
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.				
			<1 hr	≥1 hr to <2 hr	≥2 hr		
	-14	-10	(0)	2(0)[e]	3(0)[e]		
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies		
	In Zone	Outside Zone	In Zone	In Adjacent Zone			
	-11	-5	-6	-2	(0)		
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone				
	-5(0)[c]	0	3				
10. Emergency Movement Routes	<2 Routes	Multiple Routes					
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)		
	(-8)	-2	0	1	5		
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm				
			W/O F.D. Conn.	W/F.D. Conn			
	-4		1	(2)			
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone		
	0(3)[g]	2(3)[g]	3(3)[g]	4	5		
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building				
	0	8	(10)				

NOTE:

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

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

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

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
1st story	11	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	(9)	17(14)[a]	(6)	10(7)[a]	(3)
4th story or higher	18	9	19(16)[a]	6	11(8)[a]	3

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

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

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

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

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

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

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

TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET				
Complete one copy of this worksheet for each facility. For each consideration, select and mark the appropriate column.		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	√		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			√
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	√		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	√		
E.	There are no flue-fed incinerators.	√		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	√		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	√		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	√		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	√		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	√		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	√		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			√

CONCLUSIONS

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

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

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

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

Form Approved
OMB No. 0938-0242

ZONE 2 OF 3 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
SOUTHSIDE CARE CENTER	01-MAIN BUILDING
ZONE(S) EVALUATED: FIRST FLOOR	
PROVIDER/VENDOR NO. 24E507	DATE OF SURVEY 02/13/13

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

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

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

TABLE 3A. (NEW BUILDINGS)

F		R
1.0 X	[ ]	= [ ]

TABLE 3B. (EXISTING BUILDINGS)

F		R
0.6 X	7.9	= 4.7 = 5

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

SURVEYOR SIGNATURE	TITLE	DATE
Robert S. Smith — FIRE SAFETY RESOURCES, LLC	PRESIDENT	02/14/13
FIRE AUTHORITY SIGNATURE	TITLE	DATE
Fire Safety Supervisor	State Fire Marshal	3-4-13

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

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

TABLE 4.

Safety Parameters	Safety Parameters Values						
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II		
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433
First	(-2)	0	-2	0	0	2	2
Second	-7	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A				
	-5(0)[f]	0(3)[f]	(3)				
3. Interior Finish (Rooms)	Class C	Class B	Class A				
	-3(1)[f]	1(3)[f]	(3)				
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	≥½ to <1 hour	≥1 hour			
	-10(0)[a]	0	(1)0)[a]	2(0)[a]			
5. Doors to Corridor	No Door	<20 min FPR	≥20 min FPR	≥20 min FPR and Auto Clos.			
	-10	0	(1)0)[d]	2(0)[d]			
6. Zone Dimensions	Dead End			No Dead Ends >30 ft and Zone Length Is			
	>100 ft	>50 ft to 100 ft	30 ft to 50 ft	>150 ft	100 ft to 150 ft	<100 ft	
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c]	0	1	
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.				
			<1 hr	≥1 hr to <2 hr	≥2 hr		
	-14	-10	(0)	2(0)[e]	3(0)[e]		
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies		
	In Zone	Outside Zone	In Zone	In Adjacent Zone			
	-11	-5	-6	-2	(0)		
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone				
	-5(0)[c]	0	3				
10. Emergency Movement Routes	<2 Routes	Multiple Routes					
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)		
	(-8)	-2	0	1	5		
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm				
			W/O F.D. Conn.	W/F.D. Conn			
	-4		1	(2)			
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone		
	0(3)[g]	2(3)[g]	3(3)[g]	4	5		
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building				
	0	8	(10)				

NOTE:

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

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

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

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
1st story	11	(5)	15(12)[a]	(4)	8(5)[a]	(1)
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher	18	9	19(16)[a]	6	11(8)[a]	3

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

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

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

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

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

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

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

TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET				
Complete one copy of this worksheet for each facility. For each consideration, select and mark the appropriate column.		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	√		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			√
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	√		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	√		
E.	There are no flue-fed incinerators.	√		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	√		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	√		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	√		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	√		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	√		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	√		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			√

CONCLUSIONS

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

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

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

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

Form Approved
OMB No. 0938-0242

ZONE 1 OF 3 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
SOUTHSIDE CARE CENTER	01-MAIN BUILDING
ZONE(S) EVALUATED: BASEMENT	
PROVIDER/VENDOR NO. 24E507	DATE OF SURVEY 02/13/13

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

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

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

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X		=	

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X	1.6	=	1

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

SURVEYOR SIGNATURE	TITLE	DATE
Robert J Smith, FIRE SAFETY RESOURCES, LLC	PRESIDENT	02/14/13
FIRE AUTHORITY SIGNATURE	TITLE Fire Safety Supervisor / State Fire Marshal	DATE 3-4-13

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

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

TABLE 4.

Safety Parameters	Safety Parameters Values						
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II		
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433
First	-2	0	-2	0	0	2	2
Second	(-7)	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A				
	-5(0)[f]	0(3)[f]	(3)				
3. Interior Finish (Rooms)	Class C	Class B	Class A				
	-3(1)[f]	1(3)[f]	(3)				
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	≥½ to <1 hour	≥1 hour			
	-10(0)[a]	0	(1(0)[a])	2(0)[a]			
5. Doors to Corridor	No Door	<20 min FPR	≥20 min FPR	≥20 min FPR and Auto Clos.			
	-10	0	1(0)[d]	(2(0)[d])			
6. Zone Dimensions	Dead End			No Dead Ends >30 ft and Zone Length Is			
	>100 ft	>50 ft to 100 ft	30 ft to 50 ft	>150 ft	100 ft to 150 ft	<100 ft	
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c]	0	1	
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.				
			<1 hr	≥1 hr to <2 hr	≥2 hr		
	-14	-10	(0)	2(0)[e]	3(0)[e]		
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies		
	In Zone	Outside Zone	In Zone	In Adjacent Zone			
	-11	-5	-6	-2	(0)		
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone				
	-5(0)[c]	0	3				
10. Emergency Movement Routes	<2 Routes	Multiple Routes					
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)		
	(-8)	-2	0	1	5		
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm				
			W/O F.D. Conn.	W/F.D. Conn			
	-4		1	(2)			
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone		
	0(3)[g]	2(3)[g]	3(3)[g]	4	5		
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building				
	0	8	(10)				

NOTE:

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

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

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

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

[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.

FIRE SAFETY EVALUATION

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

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

What follows is a report on the results of a fire safety evaluation of the above-named facility that was conducted during an on-site visit to the facility between 0855 hours and 1055 hours on 02/13/13. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(01), *Guide to Alternative Approaches to Life Safety*. Based on this evaluation, Southside Care Center has achieved a passing score on the FSES.

In addition to the 02/13/13 walkthrough of the facility, the findings outlined herein are based on information provided by Mr. Alan Kronfeld, co-owner; Mr. Mark Anderson, Administrator; Mr. Emmanuel Tandoh, Program Director; and Mr. Mike Kelley, Maintenance; and a review of the draft Statement of Deficiencies from a fire/life safety recertification survey conducted on 02/07/13.

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

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

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

Southside Care Center is two stories in height and has a full basement. For purposes of this FSES, each of the three levels was treated as a separate zone. With the exception of Table 8, which applies to all zones, this narrative will address each of the three zones separately.

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

The facility has a manual fire alarm system, which is monitored for automatic fire department notification. As noted later in this report, there are system-connected automatic smoke detectors on all three levels of the building. Based on documentation review, the fire alarm system and smoke detectors are being inspected, tested and maintained in accordance with NFPA 72.

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

All Levels – TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

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

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

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

Zone 1 – Basement Level:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

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

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -7]:
   Because of exposed wood joists found in the basement ceiling, the building was assigned a Type V(000) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Interior finish in spaces that could be considered part of a corridor was plaster.
3. Interior Finish (Rooms) [Score: +3]:
   Interior finish in rooms was plaster; in some places gypsum wallboard has been added.

4. Corridor Partitions/Walls [Score: +1]:
   For purposes of this FSES, the basement level was treated as a single hazardous area consisting of multiple rooms. The wall separating the basement from the exitway was found to be constructed of plaster/gypsum wallboard on wood lath on both sides of wood studs, which likely provides a fire resistance of at least ½-hour.
5. Doors to Corridor [Score: +2]:
   For purposes of this FSES, the door at the bottom of the stairway leading from the basement was treated as a corridor door. The 90-minute fire-rated door in a wood frame was found to be self-closing.
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. The building measures approximately 70 feet in length on this level and Parameter 10 was assigned a score of -8. There is only one means of egress from this level. This results in a dead-end condition.
7. Vertical Openings [Score: 0]:
   A 90-minute fire-rated self-closing door in a wood frame was found at the bottom of the basement stairs. Because of the wood frame, enclosure protection of less than 1 hour is provided.
8. Hazardous Areas [Score: 0]:
   Again, for purposes of this FSES, the basement level was treated as a single hazardous area consisting of multiple rooms. This level is sprinkler protected throughout as required by NFPA 101A(01), Sec. 4.6.8.2 and smoke-separated as required by NFPA 101(00), Sec. 19.3.2.1.
9. Smoke Control [Score: 0]:
   This score was assigned per Footnote c to this Table and the fact that residents are not allowed on this level.
10. Emergency Movement Routes [Score: -8]:
    This score was assigned for the following reasons:
    - There is only one way out of the basement, which does not meet the requirements of NFPA 101(00), Sec. 19.2.4.1.
    - The path of travel is up a stairway that is enclosed with construction having less than 1-hour fire resistance as described in Item 7, Vertical Openings, above.
    - The door to the exterior from the stair enclosure is only 30.5 inches in clear width.
    - Headroom at the bottom of the basement stairway was found to be only 63 inches instead of the 80 inches required by NFPA 101(00), Sec. 7.1.5.
11. Manual Fire Alarm [Score: +2]:
    There is a manual fire alarm pull station along the path of travel from the basement. The building's fire alarm system is monitored by Criticom.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in NFPA 101A(01), Sec. 4.6.13.4.3 and Footnote *g* to this Table. The zone is protected with quick-response sprinklers. There is a system-connected smoke detector near the building's fire alarm control panel and another in the 'hallway' leading to the boiler room. Because this coverage is not included in any of the categories of NFPA 101A(01), Sections 4.6.12.2 through 4.6.12.5, this Parameter was scored as "None".
13. Automatic Sprinklers [Score: +10]:
    The building is protected by a supervised, wet-pipe automatic fire sprinkler system consisting of quick-response sprinklers.

Zone 2 – First Floor:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

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

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -2]:
   Because of exposed wood joists found in the basement ceiling, the building was assigned a Type V(000) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Interior finish was found to be plaster or gypsum wallboard or a combination thereof.
3. Interior Finish (Rooms) [Score: +3]:
   Interior finish was found to be plaster or gypsum wallboard or a combination thereof.
4. Corridor Partitions/Walls [Score: +1]:
   Corridor walls are constructed of ½-inch thick gypsum wallboard installed over plaster on wood lath on both sides of wood studs, which likely provides a fire resistance of at least ½-hour.
5. Doors to Corridor [Score: +1]:
   Corridor doors were found to be of 1-3/4-inch solid wood construction. The bathroom doors were found to be of hollow core wood construction, but pursuant to direction given in NFPA 101A(00), Sec. 4.6.5, these doors were not considered in classifying doors to corridors, as no flammable or combustible materials were found in the rooms.
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. The building measures approximately 70 feet in length on this level and Parameter 10 was assigned a score of -8. There is only one complying means of egress out of this level, which creates a dead-end condition.
7. Vertical Openings [Score: 0]:
   While the self-closing door opening from the kitchen into the west stairway was found to be a 90-minute fire-rated assembly (including a metal frame), the stair enclosure walls are constructed of plaster on wood lath/gypsum wallboard on wood studs, which likely does not provide the 1-hour fire resistance required by NFPA 101(00), Sec. 19.3.1.1.
8. Hazardous Areas [Score: 0]:
   Hazardous areas were found to be sprinkler protected as required by NFPA 101A(01), Sec. 4.6.8.2 and smoke-separated as required by NFPA 101(00), Sec. 19.3.2.1.

9. Smoke Control [Score: 0]:
   This score was assigned per Footnote c to this Table (fewer than 31 residents).
10. Emergency Movement Routes [Score: -8]:
    While there are two ways out of this level, access to the rear (west) exit passes through the kitchen, which does not meet the requirements of NFPA 101(00), Sec. 7.5.1.7. From the kitchen, occupants must pass through a door that opens into the west stairway enclosure from the Second Floor. The door to the exterior from this enclosure is only 30.5 inches in clear width. The following deficient conditions were also noted:
    - The corridor narrows to 32 inches clear width because of the desk serving as the nurse station,
    - Resident room doors were found to be only 29.5 inches in clear width and, therefore, could not be credited as an egress route [see NFPA 101A(01), Sec. 4.6.10.3.2].
11. Manual Fire Alarm [Score: +2]:
    There are manual fire alarm pull stations at the front and back doors. The fire alarm system is monitored by Criticom.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in NFPA 101A(01), Sec. 4.6.13.4.3 and Footnote *g* to this Table. The zone is protected with quick-response sprinklers. System-connected smoke detectors were found in the Day Room/Dining Room area and in the corridors leading to the main entrance and to the kitchen. This was scored as "Corridor Only" smoke detection. Battery-operated single station smoke detectors were found in the resident sleeping rooms.
13. Automatic Sprinklers [Score: +10]:
    The building is protected by a supervised, wet-pipe automatic fire sprinkler system consisting of quick-response sprinklers.

Zone 3 – Second Floor:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

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

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

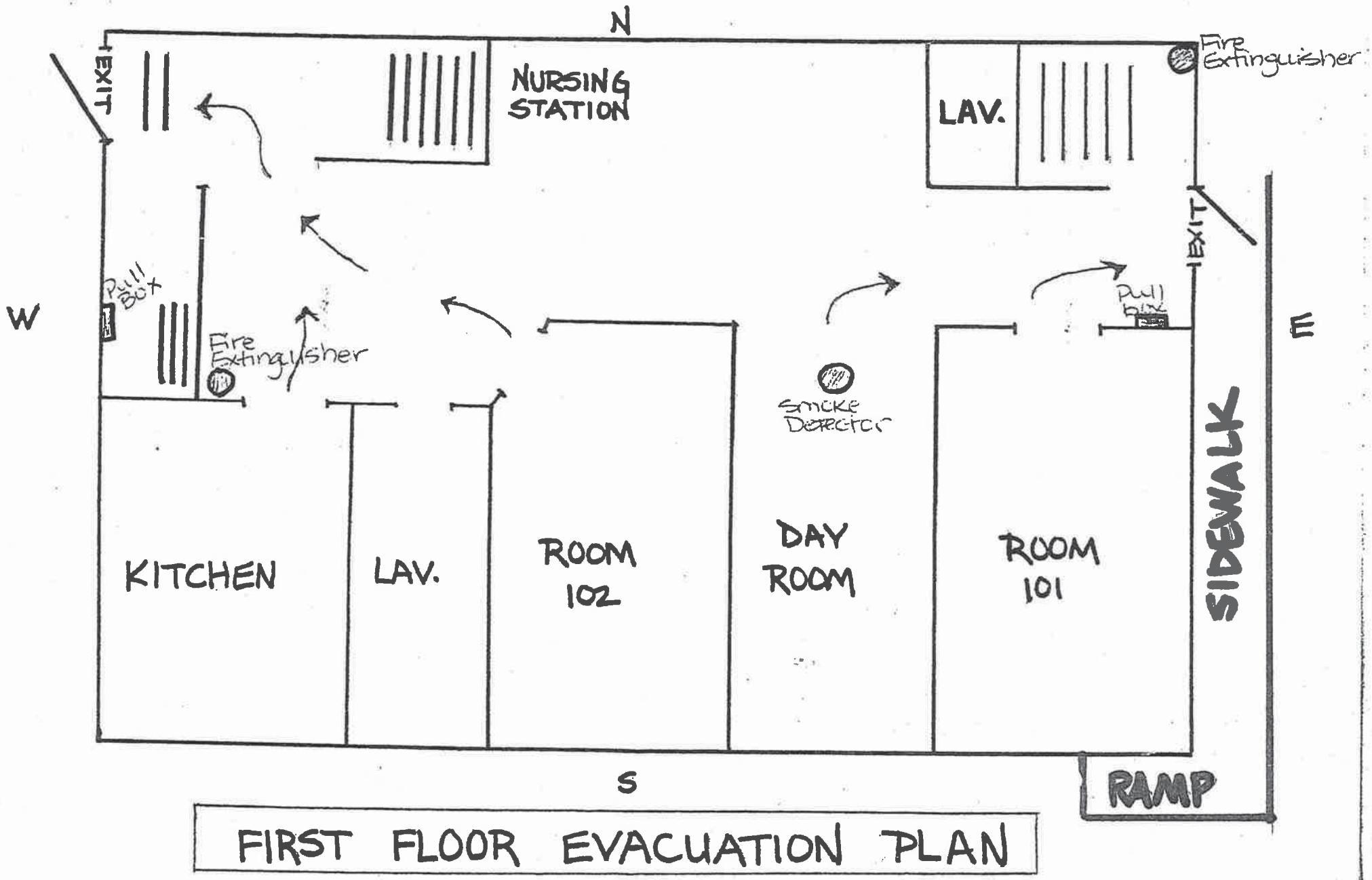
1. Construction [Score: -7]:
   Because of exposed wood joists found in the basement ceiling, the building was assigned a Type V(000) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Interior finish was found to be plaster or gypsum wallboard or a combination thereof.

3. Interior Finish (Rooms) [Score: +3]:
   Interior finish was found to be plaster or gypsum wallboard or a combination thereof.
4. Corridor Partitions/Walls [Score: 0]:
   Corridor walls are constructed of ½-inch thick gypsum wallboard installed over plaster on wood lath on both sides of wood studs. Because it appears that the corridor walls do not extend to the underside of the roof above, they were graded as "< ½ hour" in accordance with NFPA 101A(01), Sec. 4.6.4.2.
5. Doors to Corridor [Score: +1]:
   Corridor doors were found to be of 1-3/4-inch solid wood construction. The door to the bathroom was found to be of hollow core wood construction, but pursuant to direction given in NFPA 101A(00), Sec. 4.6.5, this door was not considered in classifying doors to corridors, as no flammable or combustible materials were found in the room.
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. The building measures approximately 70 feet in length on this level and Parameter 10 was assigned a score of -8. Due to the lack of complying means of egress out of this level, a dead-end condition is created.
7. Vertical Openings [Score: 0]:
   Twenty-minute-rated self-closing doors in steel frames were found at the top of the east and west stairways. The vertical openings, therefore, provide protection of less than the 1-hour fire resistance required by NFPA 101(00), Sec. 19.3.1.1
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.
9. Smoke Control [Score: 0]:
   This score was assigned per Footnote c to this Table (fewer than 31 residents).
10. Emergency Movement Routes [Score: -8]:
    There are two ways out of this level. However, as indicated in Item 7, Vertical Openings, the stair enclosures serving this level currently provide protection of less than 1-hour fire resistance, which does not meet the requirements of NFPA 101(00), Sections 7.2.2.5.1 and 7.1.3.2. The following deficient conditions were also noted:
    - The door to the exterior from the rear (west) stair enclosure is only 30.5 inches in clear width.
    - The door at the top of the front (east) stair enclosure, which used to swing over the stairs, was found to have been changed to swing into the corridor, which does not meet the requirements of NFPA 101(00), Sec. 7.2.1.4.3, and
    - Resident room doors were found to measure between 29 and 30 inches in clear width and, therefore, could not be credited as an egress route [see NFPA 101A(01), Sec. 4.6.10.3.2].
11. Manual Fire Alarm [Score: +2]:
    One manual fire alarm pull station was found at the door to the west stair. This appears to meet the intent of Exception No. 1 to NFPA 101(00), Sec. 19.3.4.2. The fire alarm system is monitored by Criticom.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in NFPA 101A(01), Sec. 4.6.13.4.3 and Footnote *g* to this Table. The zone is protected with quick-response sprinklers. A system-connected smoke detector was found in the corridor. Battery-operated single station smoke detectors were found in the resident sleeping rooms.
13. Automatic Sprinklers [Score: +10]:
    The building is protected by a supervised, wet-pipe automatic fire sprinkler system consisting of quick-response sprinklers.

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

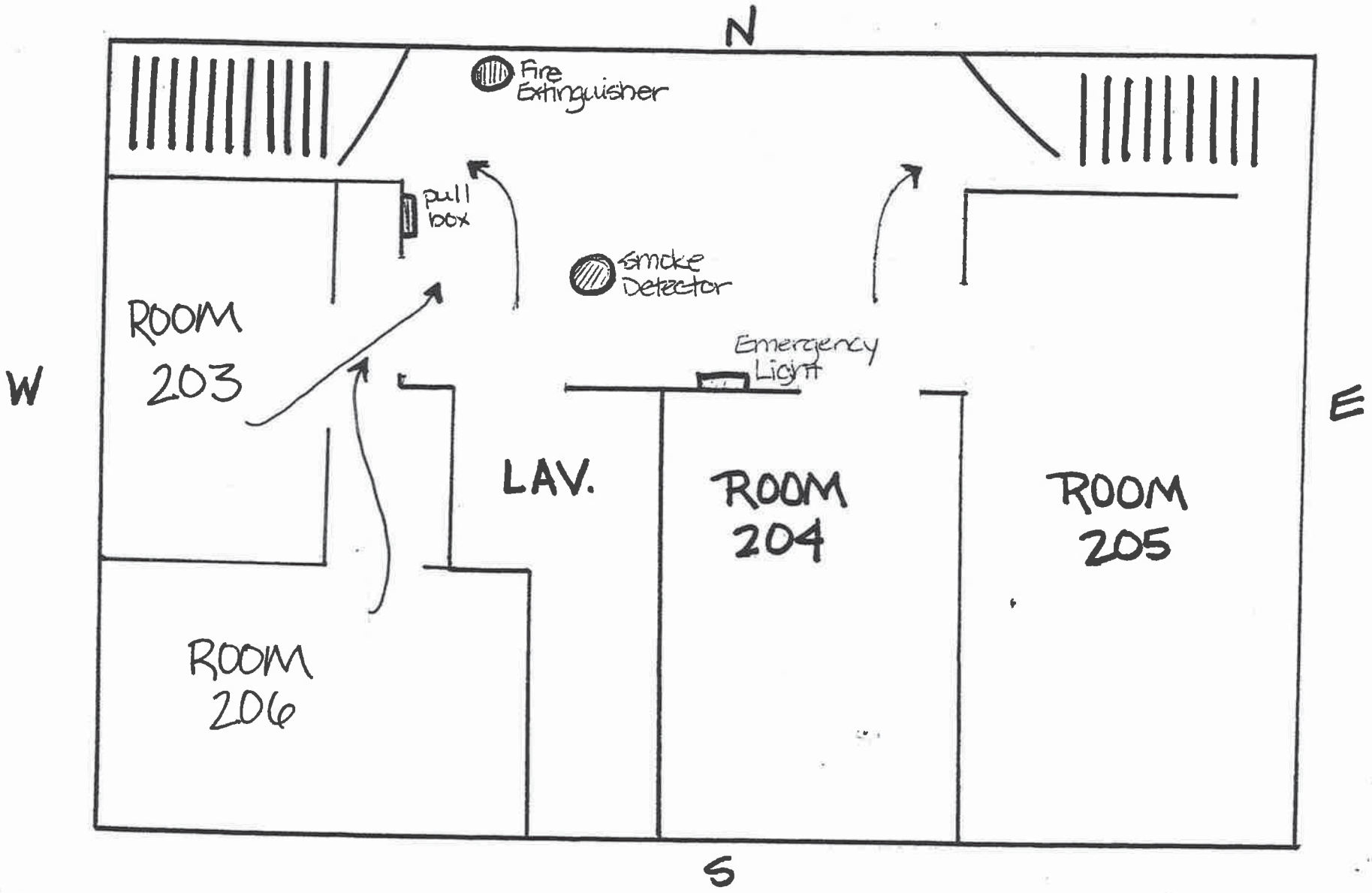
It must be noted that the scores and values assigned to the parameters in the tables on the FSES worksheets were based on conditions found between 0855 hours and 1055 hours on 02/13/13. Any changes in those conditions after that date could affect the scores and values, either positively or negatively. Again, based on this evaluation, Southside Care Center **has** achieved a passing score on the FSES. No other assessment of the level of safety in this facility is either intended or implied by *Fire Safety Resources, LLC.*

SOUTHSIDE CARE CENTER



FIRST FLOOR EVACUATION PLAN

SOUTHSIDE CARE CENTER



SECOND FLOOR EVACUATION PLAN