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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: H8ME

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00208

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E150**

2.STATE VENDOR OR MEDICAID NO.
(L2) **950842200**

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

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/27/2013** (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)
09/30

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

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

13.Total Certified Beds **20** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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
		20		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Unit Supervisor 03/27/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 04/08/2013 (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
03/31/1974
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS
Posted 04/08/2013 CO. H8ME12

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/04/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN# 24E150

A standard OTC survey was completed at this facility on December 11, 2012. The most serious deficiencies were issued at a S/S level of F.

A PCR of the LSC deficiencies was completed on January 30, 2013 and the LSC deficiencies were all determined to be corrected. However, at the time of the February 25, 2013 notice compliance of the health deficiencies could not be verified. At this time, we still did not have an acceptable plan of correction. As a result we notified the facility on February 25, 2013 that the following remedy was being imposed:

- Mandatory DOPNA effective March 6, 2013

Since we did not have an acceptable plan of correction, we also notified the facility of the following additional remedy:

- Per instance civil money penalty of $1,000.00, effective January 21, 2013, for a total penalty of $1,000.00

A Health PCR was completed on February 27, 2013 and the facility was determined to be in compliance as of February 6, 2013. We recommended the following action to DHS and DHS concurred:

- Mandatory DOPNA effective March 6, 2013, be rescinded
- Per instance civil money penalty of $1,000.00, effective January 21, 2013, for a total penalty of $1,000.00 be withdrawn

The facility's request for continuing waivers involving the deficiencies cited at F354 - Seven Day Registered Nurse coverage and
F458 - Resident Room size requirements is recommended for approval. Documentation supporting the waiver request is attached.

Because the facility is operating under a waiver of F354 for Seven Day Registered Nurse coverage, it is subject to a prohibition from offering or conducting a Nursing Assistant Training and/or competency Evaluation Program (NATCEP).

Also, see attached Fire Safety Evaluation System (FSES) dated December 19, 2012 for Life Safety Code results and CMS-2567B dated February 27, 2013.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24E150

April 8, 2013

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

Dear Mr. Soderbeck:

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

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

Effective February 6, 2013 the above facility is certified for:

20 Nursing Facility II Beds

Your facility's Medicare approved area consists of all 20 nursing facility beds.

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

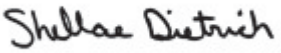
If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Program.

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

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

Please contact me if you have any questions.

Sincerely,



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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 27, 2013

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

RE: Project Number SE150022

Dear Mr. Soderbeck:

On February 25, 2013, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 6, 2013. (42 CFR 488.417 (b))

Also, we notified you in our letter of February 25, 2013, we recommended to Minnesota Department of Human Services that the following remedy be imposed:

- Per instance civil money penalty of $1,000.00, effective January 21, 2013, for a total penalty of $1,000.00

This was based on the deficiencies cited by this Department for a standard survey completed on December 11, 2012, and lack of verification of substantial compliance with the health deficiencies at the time of our February 25, 2013 notice. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On February 27, 2013, the Minnesota Department of Health and on January 30, 2013, the Minnesota Department of Public Safety completed a Post Certification Revisit (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 December 11, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 6, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 11, 2012, as of February 6, 2013.

As a result of the PCR findings, this Department recommended to the Minnesota Department of Human Services, the following actions related to the remedies outlined in our letter of February 25, 2013. The Minnesota Department of Human Services concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 6, 2013, be rescinded. (42 CFR 488.417 (b))

- Per instance civil money penalty of $1,000.00, effective January 21, 2013, for a total penalty of $1,000.00 be withdrawn.

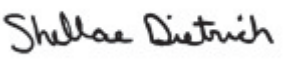
Your request for a continuing waiver involving the deficiency cited under F458 at the time of the December 11, 2012 standard survey has been approved.

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

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

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 E150r213.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
24E150	A. Building B. Wing	2/27/2013

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0159** Reg. # **483.10(c)(2)-(5)** LSC	Correction Completed **01/15/2013**	ID Prefix **F0161** Reg. # **483.10(c)(7)** LSC	Correction Completed **02/06/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **01/07/2013**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **01/07/2013**	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	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/sd	02/27/13	15507	02/27/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 12/6/2012

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E150	A. Building B. Wing **01 - MAIN BUILDING 01**	1/30/2013

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **12/19/2012**	ID Prefix	Correction Completed **12/19/2012**	ID Prefix	Correction Completed **12/19/2012**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0012		LSC K0032		LSC K0033	
ID Prefix	Correction Completed **12/19/2012**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0039		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/sd	02/27/13	28120	01/30/13
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 12/11/2012

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: H8ME

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00208

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/06/2012** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

13.Total Certified Beds **20** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
		20		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Sue Miller, HFE NE II 02/26/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 03/01/2013 (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
03/31/1974
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS
Posted 3/4/2013 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# 24E150

At the time of the standard survey completed December 11, 2012, 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 were 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 continuing waivers involving the deficiencies cited at F354 - Seven Day Registered Nurse coverage and F458 - Resident Room size requirements is recommended for approval. Documentation supporting the waiver request is attached.

Because the facility is operating under a waiver of F354 for Seven Day Registered Nurse coverage, it is subject to a prohibition from offering or conducting a Nursing Assistant Training and/or competency Evaluation Program (NATCEP).

Also, see attached Fire Safety Evaluation System (FSES) dated December 19, 2012 for Life Safety Code results.
Post Certification Revisit to follow.

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: H8ME

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00208

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/06/2012** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

13.Total Certified Beds **20** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With
Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
		20		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Sue Miller, HFE NE II — 02/26/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Shellae Dietrich, Program Specialist — 03/01/2013 (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
03/31/1974
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS
Posted 3/4/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
3-4-2013 (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

REVISED LETTER

February 25, 2013

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

Re: Project Number SE150022

Dear Mr. Soderbeck:

PLEASE NOTE: This letter will replace the letter dated February 14, 2013. Deficiency F309 was referenced incorrectly in this letter. The correct deficiency is F329.

We have received the form, Statement of Deficiencies and Plan of Correction CMS-2567, which was sent as a result of a survey completed on December 11, 2012 by the survey staff of the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and Certification Program.

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

F159 - Residents have the right to have their money held in a secure manner by the facility. If the amount is over $50 it must be held in an interest bearing account. Regardless of the difficulty it poses for the facility, and regardless of what you may have been told by a surveyor in the past, you are not meeting the intent of the regulation with the plan you propose.

F329 - The facility is correct in stating the deficiency was incorrectly noted as R16 in the opening statement, however, the information sent does not show the information was written incorrectly by the surveyor. Although the MD writes that R5 will be reviewed at the next visit, the MD did not provide a rationale at the time of the survey to support the continued use of the medication. Information sent dated December 20, 2012 was after the survey. Action was needed at the time, and the fact that the resident has since been seen by the physician can be noted in your plan.

Compliance with the health deficiencies issued pursuant to the December 11, 2012 standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required. Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require

that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective March 6, 2013

In addition, as you were informed in our letter dated January 7, 2013, if an unacceptable Plan of Correction was not received within 10 days, we would recommend imposition of the following remedies:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 448.417(a));

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

Therefore, we are recommending to the State Medicaid Agency, the Minnesota Department of Human Services that the following remedy be imposed:

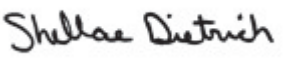
- Per instance civil money penalty of $1,000.00, effective January 21, 2013, for a total penalty of $1,000.00 (due to unacceptable PoC)

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

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

Please feel free to call me with any questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4106 Fax: (651) 215-9697
Enclosure
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 8953 7259

January 7, 2013

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

RE: Project Number SE150022, HE150002 and HE150003

Dear Mr. Soderbeck:

On December 11, 2012, 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. In addition, at the time of the December 11, 2012 standard survey the Minnesota Department of Health completed an investigation of complaint number HE150002 and HEHE150003.

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. In addition, at the time of the December 11, 2012 standard survey the Minnesota Department of Health completed an investigation of complaint number HE150002 and HEHE150003 that was found to be unsubstantiated.

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;

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

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

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

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

DEPARTMENT CONTACT

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

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

Telephone: (651) 201-3794

Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 15, 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 January 15, 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 March 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 June 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:

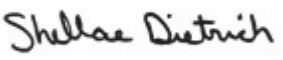
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

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 E150s13.rtf

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

January 15, 2013

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

RE: Provider ID 24E160, ~~F-355~~ F354 Waiver Request, CMS-2567 dated 12/06/2012

We request a waiver regarding providing Register Nurse (RN) coverage for eight hours per day, seven days per week.

We are requesting the waiver because:

1. Our home is licensed as a board and care home, not as a skilled nursing facility. Due to our Medicaid funding, we are surveyed the same as a skilled facility. This is a small home-like facility.

2. Our facility employs a licensed nurse at all times, seven days per week, twenty four hours per day.

3. Our resident base diagnosis' includes mental illness and/or mental retardation. The resident case-mix acuity is low and we generally only care for residents who do not require significant or complicated medical nursing interventions or treatments.

4. The Licensed Practical Nurses (LPN) whom we employ are all experienced nurses and with psychological nursing experience. This experience is invaluable with our typical resident case-mix and acuity.

5. We do and have tried to maintain more RN coverage. When we are in need of staff, we advertise for licensed nurses. (Either RN/LPN). In addition, we have found that the LPNs have a longer average tenure which benefits our residents.

6. With only twenty beds, we have adequate staffing to meet our resident needs. We generally employ one licensed nurse per shift, but increase the number of nurses on shift to provide administrative time to the Director of Nursing.

7. All nurses report directly to the Director of Nursing. The Director of Nursing, a registered nurse, works an average of 40 hours per week or more and is available 24 hours per day, seven days a week by cell phone. The Director of Nursing carries a facility provided cell phone. Nursing has not had any problems providing care and availability of the Director of Nursing has not been an issue.

This waiver was approved in previous years but under F354. ~~This is the first year this was cited under F355~~ changed tag to 354. per email to admin. 3/1/13

Sincerely,

Allen Soderbeck
Administrator

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

January 15, 2013

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

RE: Provider ID 24E150, F-458 Waiver Request, CMS-2567 dated 12/06/2012

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

We are requesting the waiver because:

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

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

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

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

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

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

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

8. Nursing has not had any problems providing care.

This has been an approved ongoing waiver for many years.

Sincerely,

Allen Soderbeck
Administrator

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
	24E150	A. BUILDING _____ B. WING _____	12/06/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Two complaint investigations were conducted at the time of the standard recertification survey. Complaint HE150003 and HE150002 were unsubstantiated.	F 000	RECEIVED JAN 2[illegible] 2013 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.	F 159	F159. The facility will continue to hold resident funds on their request going forward. When resident funds exceed $50, we will pay interest on the amount at the prevailing passbook savings rate. We will review the rate periodically. The money will continue to be available to the residents 7 days per week and all transactions are logged and the information available to the residents.	1/15/2013

POC accepted (after revisions sent to us) 2/26/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	1-18-13

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
	24E150	A. BUILDING _____ B. WING _____	12/06/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 159	Continued From page 1 The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident funds in excess of $50.00 was placed in an interest bearing account for 7 of 7 residents (R5, R11, R12, R13, R14, R16, and R18) whose personal funds were managed by the facility. Findings include:	F 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING _____ B. WING _____	12/06/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 159	Continued From page 2 A review of facility-managed resident fund account balances revealed that on 12/4/12 two resident funds accounts for R5 and R13 contained more more than $50.00. On 12/4/12 at 4:30 p.m. the office manager stated resident funds were not kept in interest bearing accounts. She said most residents managed their own money and resident funds held by the facility seldom were more than $50.00 a month. The office manager also stated she understood interest was to be paid for funds in excess of $100. On 12/6/12 at 4:40 p.m. the office manager stated the facility managed the funds for 7 of the 19 residents residing at the facility.	F 159		
F 161 SS=E	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to secure a surety bond or provide assurance for 7 of 7 residents (R5, R11, R12, R13, R14, R16, and R18) whose funds were managed by the facility. Findings include: On 12/4/12 at 1:07 p.m. evidence of a surety bond for resident funds was requested. The office manager stated she was unaware whether	F 161	F161. The facility will acquire a surety bond to cover the resident money that is being held.	2/6/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING _____ B. WING _____	12/06/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 161	Continued From page 3 the facility had purchased a surety bond in the amount equal to or greater than personal funds held by the facility. On 12/6/12 at 11:35 a.m. the office manager stated she knew the facility did not have a certificate of deposit to cover resident funds, but still needed to check whether they had a surety bond. The manager stated there was never more than a couple hundred dollars held by the facility for residents. At 4:40 p.m. she stated they only managed money for 7 of the 19 residents residing at the facility, and confirmed they did not have a surety bond.	F 161		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide appropriate oral care to 1 of 1 resident (R16) in the sample who had problems with a dry mouth. Findings include: R16 stated she did not receive enough fluid in between meals when interviewed on 12/3/12 at 6:00 p.m. During the interview R16 was	F 309	F309. Weekly oral checks have been added to R16 treatment sheet. This will ensure any lesions, dryness, and edema/gingival will be noted and action taken. Bilolene mouth rinse has been provided and is being administered as directed when brushing teeth BID. This has also been added to the treatment sheet. We have changed the new order procedure. All new orders are now written into a "new orders" notebook. New orders are processed by the nurse on duty taking the new order and the 11-7 nurse validates that it was documented in the proper places and the proper actions are taking place. The DON reviews and supervises the process Monday Friday. New orders received on the weekend will be reviewed on Monday. This new procedure and any improvements necessary will be reviewed during the next four QA quarterly meetings.	1/7/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING _____ B. WING _____	12/06/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 4 observed to be mouth breathing and the inner mucosa of her mouth appeared dry. Again on 12/6/12 at 9:40 a.m. mouth breathing and a dry inner mucosa was observed. R16 was drinking a large cup of coffee. At 10:15 a.m. she was drinking a diet, caffinated soda. R16 informed the surveyor she drank a diet Pepsi every day at 10:00 a.m. and 2:30 p.m. Record review revealed R16 had been diagnoses with Stage IV head and neck cancer at the beginning of 2012, and over the summer had completed rounds of chemotherapy and radiation. A dental referral form dated 11/6/12 revealed, that at the time of the dental visit, R16 had a dry mouth, a lesion on the floor of the mouth, moderate plaque, and edematous gingiva. The dentist recommended R16 brush their teeth twice a day, floss daily, use "Biotene dry mouth products," avoid alcohol, and sip water. A notation on the referral form revealed the recommendations were noted by a facility nurse, however, the recommendations were not being implemented. There was no indication the facility had ordered Biotene or other similar dry mouth product, was ensuring R16 brushed and flossed her teeth according to the dentist's recommendations or that facility staff were monitoring R16's mouth for lesions. On 12/6/12 at 11:20 a.m. a copy of R16's care plan dated 10/19/12 and dental visit of 11/6/12 was requested of the director of nursing (DON). She stated she usually did things correctly, but made no other comment about the dental recommendations.	F 309		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING _____ B. WING _____	12/06/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329 SS=D	Continued From page 5 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure consulting pharmacist's recommendations received follow up by the facility and physician for 1 of 8 residents (R4) who had pharmacy recommendations. Findings include:	F 329	F329. The ranitidine order has been changed for resident R4 reducing from BID to QID consistent with the consulting pharmacist recommendation sheet. We have modified the procedure to process the consulting pharmacist requests after receipt back from the physician. After receipt and when action is required, nursing will process the change and then file these forms in the consulting pharmacy book. The 11-7 nurse validates that it was documented in the proper places and the proper actions are taking place. This task has been added to the 11-7 nursing checklist. The DON reviews and supervises the process Monday – Friday. New orders received on the weekend will be reviewed on Monday. This new procedure and any improvements necessary will be reviewed during the next four QA quarterly meetings.	1/7/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING _____ B. WING _____	12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND AVENUE REST HOME	3966 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 6 R4's pharmacy recommendation for related to a continued need for the current dose of ranitidine (inhibits stomach acid production) or a dose reduction after the physician agreed with the recommendation. Physician orders dated 10/16/12, indicated R4 received ranitidine 150 mg twice daily for gastroesphogeal reflux disease (GERD). R4 had received this dosage since 8/29/11, with no changes. R4's pharmacy review dated 8/17/12, indicated "[R4] is on ranitidine 150 mg twice daily for GERD since 9/2011. Regular evaluation for continued need of medications is required by CMS [Centers for Medicare and Medicaid Services] guidelines for long-term care facilities. Please document an evaluation of the continued need for therapy and consider if dose reduction to once daily dosing would be appropriate." There was no follow up by the facility with the physician as to if there was a continued need or if the dose should be reduced to once daily. An interview conducted with the director of nursing (DON) on 12/6/12, at 1:20 p.m. confirmed there was no follow up with the physician to verify the continued need of the ranitidine at 150 mg twice daily or if a dose reduction to once daily was appropriate for R4. The DON stated this was missed.	F 329		
354 F 355 SS=C	483.30(c) - (d) NURSING STAFFING WAIVERS §483.30(c) Nursing facilities Waiver of requirement to provide licensed nurses on a 24-hour basis.	354 F 355 XXX	354 F 355. We have requested a waiver for this requirement because: Our home is licensed as a board and care home, not as a skilled nursing facility. Our facility employs a licensed nurse at all times, seven days per week, twenty four hours per day. The DON is a RN working full time and is available 24x7 when not at the facility.	1/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING _____ B. WING _____	12/06/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 355 354	Continued From page 7 To the extent that a facility is unable to meet the requirements of paragraphs (a)(2) and (b)(1) of this section, a State may waive such requirements with respect to the facility if-- (1) The facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel; (2) The State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility; (3) The State finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility; (4) A waiver granted under the conditions listed in paragraph (c) of this section is subject to annual State review; (5) In granting or renewing a waiver, a facility may be required by the State to use other qualified, licensed personnel; (6) The State agency granting a waiver of such requirements provides notice of the waiver to the State long term care ombudsman (established under section 307 (a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and mentally retarded; and (7) The nursing facility that is granted such a	F 355 354		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING _____ B. WING _____	12/06/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 355 354	Continued From page 8 waiver by a State notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) andmembers of their immediate families of the waiver. 483.30(d) SNFs Waiver of the requirement to provide services of a registered nurse for more than 40 hours a week. (1) The Secretary may waive the requirement that a SNF provide the services of a registered nurse for more than 40 hours a week, including a director of nursing specified in paragraph (b) of this section, if the Secretary finds that -- (i) The facility is located in a rural area and the supply of skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area; (ii) The facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week; and (iii) The facility either-- (A) Has only patients whose physicians have indicated (through physicians' orders or admission notes) that they do not require the services of a registered nurse or a physician for a 48-hours period or; (B) Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full-time	F 355 354		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING _____ B. WING _____	12/06/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 354	Continued From page 9 registered nurse is not on duty; (iv) The Secretary provides notice of the waiver to the State long term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and mentally retarded; and (v) The facility that is granted such a waiver notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver. (2) A waiver of the registered nurse requirement under paragraph (d)(1) of this section is subject to annual renewal by the Secretary. This REQUIREMENT is not met as evidenced by: Based on staff interview and document review, the facility failed to ensure a registered nurse (RN) was working for eight consecutive hours a day, seven days a week that would affect all the residents in the facility. This had the potential to affect all 19 residents. Findings include: The facility did not routinely provide required RN coverage. In an interview with the office manager at 1:30 p.m. on 12/3/12, it was verified routine RN coverage had not been provided eight hours a day, seven days a week. The facility had recently	F 354		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING _____ B. WING _____	12/06/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 355 354	Continued From page 10 hired a RN to work part time during the night shift and every other weekend. However, despite continued attempts, the facility was unable to hire a RN for the remaining open shifts. The facility demonstrated continued attempts at hiring for additional coverage but was unable to hire a RN. The director of nurses was also available by cell phone in the event of an emergency.	F 355 354		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide all residents with bedrooms which measured at least 80 square feet per resident for 8 of 20 residents (R1, R2, R4, R5, R7, R9, R11 and R14)) in the sample whose bedrooms had fewer than the required footage. Findings include: Three residents resided in room #101 that had 211.33 square feet of floor space. A large wooden wardrobe was built into the room, which measured 13.5 square feet. That left 197.83 square feet of usable space or 66 square feet for each resident. Two residents resided in room #102 at the start of the survey on 12/3/12; and a third resident was admitted after the start of the survey. It had 232 square feet of floor space or 77.3 square feet per	F 458	F458. A waiver is requested for rooms 101, 102 and 103 because they do not meet the requirements of 80 square feet per resident. We are requesting the waiver because: We have operated over 40 years in the same facility. During this time, there have been no adverse effects due to the room sizes. Our residents are generally satisfied. Our resident concerns are minimal. When a resident does have a concern it is generally because they came to our facility from an apartment or home and we cannot accommodate as many of their belongings as they would prefer. We do try to accommodate them to the extent possible. All of our residents are ambulatory. We do not have wheel chairs in the facility and have not encountered any safety or health problems due to the existing room sizes. The residents have the opportunity to decorate their room and put up different personal items of enjoyment. Our residents have ample room for personal possessions. Each resident has a custom-made locking wardrobe cabinet. There is enough room for chairs and other preferred furniture to the extent possible.. The beds in our rooms fit the space very well and allow for exit and entry without issue. Nursing has not had any problems providing nursing care.	1/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING _____ B. WING _____	12/06/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 458	Continued From page 11 resident. Three residents resided in room #103. The room had 238.26 square feet of floor space. Three wooden wardrobes were built into the room. One wardrobe measured 6 square feet; another measured 5.3 square feet and the third measured 6.25 square feet. That resulted in 220.71 square feet of useable floor space or 73.7 square feet per resident. On the afternoon of 12/3/12 and the morning of 12/4/12, all residents residing the three rooms were interviewed. The residents all reported they were satisfied with the space provided in their rooms. At 1:30 p.m. on 12/3/12, the office manager verified the facility was aware of the space requirements and the requirement to request an annual waiver related to the room sizes.	F 458		

Lantto, Gayle (MDH)

From: Lantto, Gayle (MDH)
Sent: Friday, March 01, 2013 1:38 PM
To: allen.soderbeck@frontiernet.net
Cc: Dietrich, Shellae (MDH)
Subject: Nursing waiver

Hi Allen,

When the survey was being uploaded, it was noted F355 should have been F354, so just wanted to let you know the change was made on the 2567 and to your plan. We can all hope next year there will be no moves, holidays, mistakes, misunderstandings, etc! The good news is that we recommended the $1000 fine be recinded, and that almost never happens. We felt it was a genuine misunderstanding on your part, so now we'll go on from here! Have a good weekend.

Gayle Lantto, LSW
MN Dept. of Health, Licensing & Certification
CLIA & Metro D Unit Supervisor
office: (651) 201-3794 fax: (651) 201-3790
P.O. Box 64900
St. Paul, MN 55164-0900

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

FE150021

PRINTED: 01/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/11/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Grand Avenue Rest Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	K000. This facility contracts with Fire Safety Resources, LLC to conduct a Fire Safety Evaluation each year. The FSES onsite inspection was conducted on 12/19/2011 and he facility achieved a passing score. POC ok W/FSES for K12, 32, 33 & 39 JR 1-24-13 RECEIVED JAN 24 2013	

DC: 01-15-2013
EXIT: 12-06-2012

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

Administrator 1-15-2013

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/11/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 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. This 2-story building was determined to be of Type V(000) construction. It has a basement and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to corridors which is monitored for automatic fire department notification. The facility has a capacity of 20 beds and had a census of 20 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and interview, this building	K 012	K012. This facility conducts an annual FSES and achieved a passing FSES score.	12/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/11/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 012	Continued From page 2 does not meet the requirements for construction type and height. This deficient practice could affect all residents. Findings include: During a tour of the facility between 10:15 AM and 11:30 AM on 12/11/2012, observation revealed that this 1903, 2-story, fully fire sprinklered building of Type V(000) construction does not meet the minimum construction requirements of the code for type and height. This deficient practice was verified by the administrator at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 012		
K 032 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: Based on observation and interview, two approved remote exits are not provided from the second floor. This deficient practice could affect all residents. Findings include: During a tour of the facility between 10:15 AM	K 032	K032. This facility conducts an annual FSES and achieved a passing FSES score.	12/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/11/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 032	Continued From page 3 and 11:30 AM on 12/11/2012, observation revealed that the outside fire escape stairs do not provide the required two (2) remote exits from the second floor. This deficient practice was verified by the administrator at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 032		
K 033 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observation and interview, the stairway enclosure of this facility does not meet the required one (1) hour fire resistive construction. This deficient practice could affect all residents. Findings include: During a tour of the facility between 10:15 AM and 11:30 AM on 12/11/2012, observation revealed that wall construction of the stair enclosure is constructed of plaster on wood lath on wood studs, which does not meet the one (1) hour fire resistive construction requirements for	K 033	K033. This facility conducts an annual FSES and achieved a passing FSES score.	12/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/11/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 033	Continued From page 4 this type of facility. This deficient practice was verified by the administrator at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 033		
K 039 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 This STANDARD is not met as evidenced by: Based on observation and interview, the second floor corridor does not meet the minimum 48" width requirement. This deficient practice could affect all residents. Findings include: During a tour of the facility between 10:15 AM and 11:30 AM on 12/11/2012, observation revealed that the second floor corridor is only 39 inches in clear width and not the 48 inches required for this type of facility. This deficient practice was verified by the administrator at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 039	K039. This facility conducts an annual FSES and achieved a passing FSES score.	12/19/2012

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Monday, January 28, 2013 12:48 PM
To: 'rochi_lsc@cms.hhs.gov'
Cc: Rexeisen, Robert (DPS); 'Allen Soderbeck'; 'RImholteFiresafe@aol.com'; 'Colleen Leach'; 'Jim Loveland'; 'Mark Meath'; 'Mary Henderson'; 'Shellae Dietrich'; Steege, Nicole (MDH); Whitney, Marian (DPS)
Subject: Grand Av e Rest Home (24E150) 2012 FSES Report

This is to inform you that I am accepting the FSES conducted at the Grand Ave Rest Home on 12-19-12. The exit date was 12-6-12.

I am recommending that 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

Grand Avenue Rest Home

3956 Grand Avenue South

Minneapolis, MN 55409

Provider No. 24E150

Date of Survey: December 19, 2012

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

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
GRAND AVENUE REST HOME	01-MAIN BUILDING
ZONE(S) EVALUATED	
BASEMENT	
PROVIDER/VENDOR NO.	**DATE OF SURVEY**
24E150	12/19/12

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

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

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

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X	[ ]	=	[ ]

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X	[1.6]	=	[1.0]

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

SURVEYOR SIGNATURE	TITLE	DATE
Robert V. Smith, Fire Safety Resources, LLC.	PRESIDENT	12/21/12
FIRE AUTHORITY SIGNATURE	**TITLE**	**DATE**
[signature] Fire Safety Supervisor	State Fire Marshal	1-24-13

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		
	-4		W/O F.D. Conn.	W/F.D. Conn	
			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_4 to blocks labeled S_1, S_2, S_3, S_4 in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

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

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

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

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

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

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

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

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

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

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

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

CONCLUSIONS

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

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

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

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

Form Approved
OMB No. 0938-0242

ZONE 2 OF 3 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
GRAND AVENUE REST HOME	01-MAIN BUILDING
ZONE(S) EVALUATED: FIRST FLOOR	
PROVIDER/VENDOR NO.: 24E150	DATE OF SURVEY: 12/19/12

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	1.6	X	1.5	X	1.1	X	4.0	X	1.2	=	12.7

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

TABLE 3A. (NEW BUILDINGS)

F		R
1.0 X		=

TABLE 3B. (EXISTING BUILDINGS)

F		R		
0.6 X	12.7	=	7.6	= 8

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

SURVEYOR SIGNATURE	TITLE	DATE
Robert V. Smith — FIRE SAFETY RESOURCES LLC	PRESIDENT	12/21/12
FIRE AUTHORITY SIGNATURE	TITLE	DATE
	Fire Safety Supervisor / State Fire Marshal	1-24-13

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)[e]	(0)	1(0)[e]	2(0)[e]			
5. Doors to Corridor	No Door	<20 min FPR	≥20 min FPR	≥20 min FPR and Auto 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.				
	-14	-10	<1 hr	≥1 hr to <2 hr	≥2 hr		
			(0)	2(0)[e]	3(0)[e]		
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies		
	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)[g]				

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_4 to blocks labeled S_1, S_2, S_3, S_4 in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

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

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

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

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

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

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

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

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

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

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION					Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 12 − S_a 5 = C 7	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 13 − S_b 4 = E 9	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 4 − S_c 1 = P 3	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 10 − R 8 = G 2	√	

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

CONCLUSIONS

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

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

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

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

Form Approved
OMB No. 0938-0242

ZONE 3 OF 3 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
GRAND AVENUE REST HOME	01 - MAIN BUILDING
ZONE(S) EVALUATED: SECOND FLOOR	
PROVIDER/VENDOR NO.: 24E150	DATE OF SURVEY: 12/19/12

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	1.0	X	1.5	X	1.2	X	4.0	X	1.2	=	8.6

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	8.6	=	5.2	= 6

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

SURVEYOR SIGNATURE: Robert L Vinson	FIRE SAFETY RESOURCES, LLC	TITLE: PRESIDENT	DATE: 12/21/12
FIRE AUTHORITY SIGNATURE:	Fire Safety Supervisor	TITLE: State Fire Marshal	DATE: 1-24-13

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)[a]	3(0)[a]

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_4 to blocks labeled S_1, S_2, S_3, S_4 in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

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

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

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

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

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

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

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

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

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

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

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

CONCLUSIONS

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

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

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

FIRE SAFETY EVALUATION

Name of Facility: Grand Avenue Rest Home
Address: 3956 Grand Avenue South, Minneapolis, MN 55409
Phone: 612-824-1434
Licensed capacity: 20
Census at time of survey: 20

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

What follows is a report on the findings of a fire safety evaluation of the above-named facility that was conducted during an on-site visit to the facility between 0845 hours and 1115 hours on 12/19/12. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(01), *Guide to Alternative Approaches to Life Safety*. Based on this evaluation, Grand Avenue Rest Home has achieved a passing score on the FSES.

In addition to the on-site visit on 12/19/12, the findings outlined herein are based on information provided by Mr. Allen Soderbeck, Administrator, Ms. Nancy Soderbeck; and a review of the draft Statement of Deficiencies from a fire/life safety recertification survey conducted on 12/11/12.

Initial Comments:
The building housing Grand Avenue Rest Home was constructed in 1930 with an addition in 2001. It is considered an existing building for federal certification purposes and was, therefore, treated as such for assigning values on the FSES worksheets.

Because of the noncombustible exterior walls and protected wood frame interior structural members, the major portion of the building was found to be of Type III(000) construction. While interior walls and ceilings are constructed of plaster on wood lath on wood studs, exposed wood joists were found in the ceiling in various areas of the basement. The 2001 addition to the east side of the building was found to be of protected wood frame construction, but, again, exposed wood joists were found in the ceiling of the basement crawl space. As a result, for purposes of this FSES, Grand Avenue Rest Home was considered to be of Type V(000) construction.

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.

Grand Avenue Rest Home is two stories in height and has a full basement. It is protected throughout by a supervised, dry-pipe automatic sprinkler system. For purposes of this FSES, each of the three levels was treated as a separate zone. With the exception of Table 8, which applies to all zones, this narrative will address each of the three zones separately.

The facility has a manual fire alarm system, which is monitored for automatic fire department notification. Corridor smoke detection is provided on the First and Second Floors. In addition, there are system-connected automatic smoke detectors in the storage and laundry room areas located at the west end of the basement. Based on documentation review, the fire alarm system and smoke detectors are being inspected, tested and maintained in accordance with NFPA 72.

The building is protected by a supervised, dry-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 following narrative is intended to serve as an explanation of the scores entered on Tables 1, 4 and 8 of the FSES worksheets (i.e. Forms CMS-2786T) for the facility as it was found on 12/19/12. 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. All items in Table 8 could be checked 'Met' with the exception of Items B and L. Because Grand Avenue Rest Home is an existing facility and does not meet the definition of a high rise, Items B and L were checked 'Not Applicable'.

The remaining items were identified as 'Met' based on the following:

- Building utilities and heating and air conditioning systems appeared to be in conformance with NFPA 101(00), Sec. 9.1 and 9.2.
- The facility has a policy in place restricting the use of portable space heaters to non-sleeping staff areas only. Based on review, the policy was found to be in conformance with the exception to NFPA 101(00), Sec. 19.7.8.
- No incinerator was found in the building.
- The facility's evacuation plan and fire drill records were reviewed and appeared to be in order.
- The facility restricts smoking inside the building to the smoking lounge on Second Floor. Smoking is also allowed on the porch at the southwest exterior of the building. The facility's smoking regulations were reviewed and appeared to be in order.
- Documentation was provided certifying that the facility's drapes and curtains were treated with Burn Barrier FPR Spray On Fire Retardant to render them flame resistant.
- 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

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 storage rooms, the facility heating plant and a laundry room. 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]:
   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, acoustical tile and wood paneling. Based on interview with the administrator, all acoustical tile and wood paneling was treated with Flame Control No. 20-20A Flat Latex Intumescent Fire Retardant Paint and/or Flame Control No. 40-40A Low Gloss Latex Fire Resistant Coating to achieve a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Interior finish was found to consist of plaster, acoustical tile and wood paneling. Based on interview with the administrator, all acoustical tile and wood paneling was treated with Flame Control No. 20-20A Flat Latex Intumescent Fire Retardant Paint and/or Flame Control No. 40-40A Low Gloss Latex Fire Resistant Coating to achieve a Class A (25 or less) flame spread rating.
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 reported to be constructed of plaster on wood lath on 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 door, of 1¾-inch-thick solid wood construction in a wood frame, was found to be automatic-closing.
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. The building measures approximately 60 feet in length. Due to a lack of complying means of egress, Parameter 10 was scored at -8.
7. Vertical Openings [Score: 0]:
   A 1¾-inch-thick solid wood automatic-closing door in a wood frame was found at the bottom of the basement stairs. The door at the top of the stairway was found to be of wood panel construction.
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]:
    - 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 located at the west end of the basement that is enclosed with construction having less than 1-hour fire resistance as described in Parameter 7, Vertical Openings, above.
    - The door to the exterior at the landing between First Floor and the basement was found to be only 28 inches in clear width, which does not meet the requirements of NFPA 101(00), Sec. 19.2.3.5. The door was found to be equipped with both passage hardware and a security chain. As a result, when locked, this door requires more than one releasing operation to open, which does not meet the requirements of NFPA 101(00), Sec. 7.2.1.5.4.
    - It was found that the stairway from the basement narrows to only 26½ inches in clear width. As a result, this path of travel 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 is a manual fire alarm pull station adjacent to the door at the bottom of the stairway from the basement. The fire alarm system is monitored by Trans-Alarm.
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 storage and laundry room areas located at the west end of the basement. 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, dry-pipe automatic sprinkler system consisting of quick-response sprinklers.

Zone 2 – First Floor:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 1.6]: It was reported that all residents housed in this zone are mobile and capable of removing themselves from danger exclusively by their own efforts. A review of the facility's Form CMS-672, dated 12/05/12, revealed that the mobility of one (1) of its 20 residents is classified as "Ambulation with assistance or assistive device". Based on interview with the administrator, it was determined that this resident is housed in this zone and uses a walker only when on outings away from the building.

   Based on observation and interview with the administrator, it was found that another resident housed in this zone is temporarily using a walker as she recovers from a recent surgery. This resident, a smoker, goes out to the porch at the southwest exterior of the building to smoke.

   A review of the facility's admission policy 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. Because the rate of travel for the resident using the walker due to the recent surgery appeared to be significantly slowed, it was felt that this resident did not meet the definition of "Mobile". This parameter was, therefore, scored as "Limited Mobility".
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to nine (9) residents in this zone. The zone also contains the facility living/dining room, which is available for use by all 20 residents.
3. Zone Location (*I*) [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]: It was reported that there is one (1) staff person on duty on the night shift. Because this staff person leaves the floor to make hourly rounds of the building, this Parameter was scored as "One or More over None". There are at least two staff persons on duty during meal times.
5. Patient Average Age (*A*) [Value assigned = 1.2]: It was reported that two (2) residents housed in this zone are age 65 years and over. Two (2) other residents who use the living/dining room areas are also age 65 years and over.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -2]:
   The building was assigned a Type V(000) construction type.

2. Interior Finish (Corridors and Exits) [Score: +3]:
   Based on interview with the administrator, all wood paneling in areas serving as part of the corridor/exit system was treated with Flame Control No. 20-20A Flat Latex Intumescent Fire Retardant Paint and/or Flame Control No. 40-40A Low Gloss Latex Fire Resistant Coating to achieve a Class A (25 or less) flame spread rating. Documentation was provided certifying that the drop-in acoustical ceiling tiles carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +1]:
   Based on interview with the administrator, some of the wood paneling in rooms was treated with Flame Control No. 20-20A Flat Latex Intumescent Fire Retardant Paint and/or Flame Control No. 40-40A Low Gloss Latex Fire Resistant Coating to achieve a Class A (25 or less) flame spread rating. The remaining room paneling was treated with Flame Control Fire Retardant Varnish No. 129 to achieve a Class B (75 or less) flame spread rating. Documentation was provided certifying that the drop-in acoustical ceiling tiles carry a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: 0]:
   Corridor walls are constructed of ½-inch thick plaster on wood lath on both sides of wood studs, which likely provides a fire resistance of at least ½-hour. However, an unprotected window opening was found in the wall between the office and living room, which serves as part of the corridor/exit system.
5. Doors to Corridor [Score: 0]:
   Corridor doors were found to be of wood panel and solid wood core construction.
6. Zone Dimensions [Score: +1]:
   The building measures approximately 60 feet in length on this level.
7. Vertical Openings [Score: 0]:
   A 1¾-inch-thick solid wood automatic-closing door in a wood frame was found at the bottom of the stairs between the basement and First Floor. The door at the top of the stairway was found to be of wood panel construction.
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]:
    This score was assigned for the following reasons:
    - While there are two ways out of this level, the door from the living room that provides access to the front (east) exit is only 29 inches in clear width. As a result, this path of travel could not be credited as an egress route [see NFPA 101A(01), Sec. 4.6.10.3.2].
    - The corridor doors into the resident rooms on this level were found to measure between 27½ and 31½ inches clear width. As a result, they could not be credited as an egress route [see NFPA 101A(01), Sec. 4.6.10.3.2].
    - An approximately 3-inch grade change was found outside the back (southwest) exit door, which does not meet the requirements of NFPA 101(00), Sec. 7.2.1.3.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations were found at both the front and back doors. The fire alarm system is monitored by Trans-Alarm.
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 dining room and living room areas, in the hallway leading to the kitchen and at the bottom of the stairs from the Second Floor. This parameter was, therefore, scored as "Corridor Only" smoke detection.

13. Automatic Sprinklers [Score: +10]:
    The building is protected by a supervised, dry-pipe automatic 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 mobile and capable of removing themselves from danger exclusively by their own efforts. A review of the facility's Form CMS-672, dated 12/05/12, revealed that the mobility of one (1) of its 20 residents is classified as "Ambulation with assistance or assistive device". Based on interview with the administrator, it was determined that this resident is housed on the First Floor and uses a walker only when on outings away from the building.

   Based on observation and interview with the administrator, it was found that another resident housed on the First Floor is temporarily using a walker as she recovers from a recent surgery. This resident, a smoker, goes out to the porch at the southwest exterior of the building to smoke and currently does not access the Second Floor. This parameter was, therefore, scored as "Mobile".
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to eleven (11) residents in this zone. This zone also contains the facility smoking lounge, which, per facility policy, is available for use by an additional three (3) residents at any one time.
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]: It was reported that there is only one (1) staff person on duty on the night shift. This staff person is located on First Floor, but makes hourly rounds of the building.
5. Patient Average Age (*A*) [Value assigned = 1.2]: It was reported that two (2) residents housed in this zone are age 65 years and over.

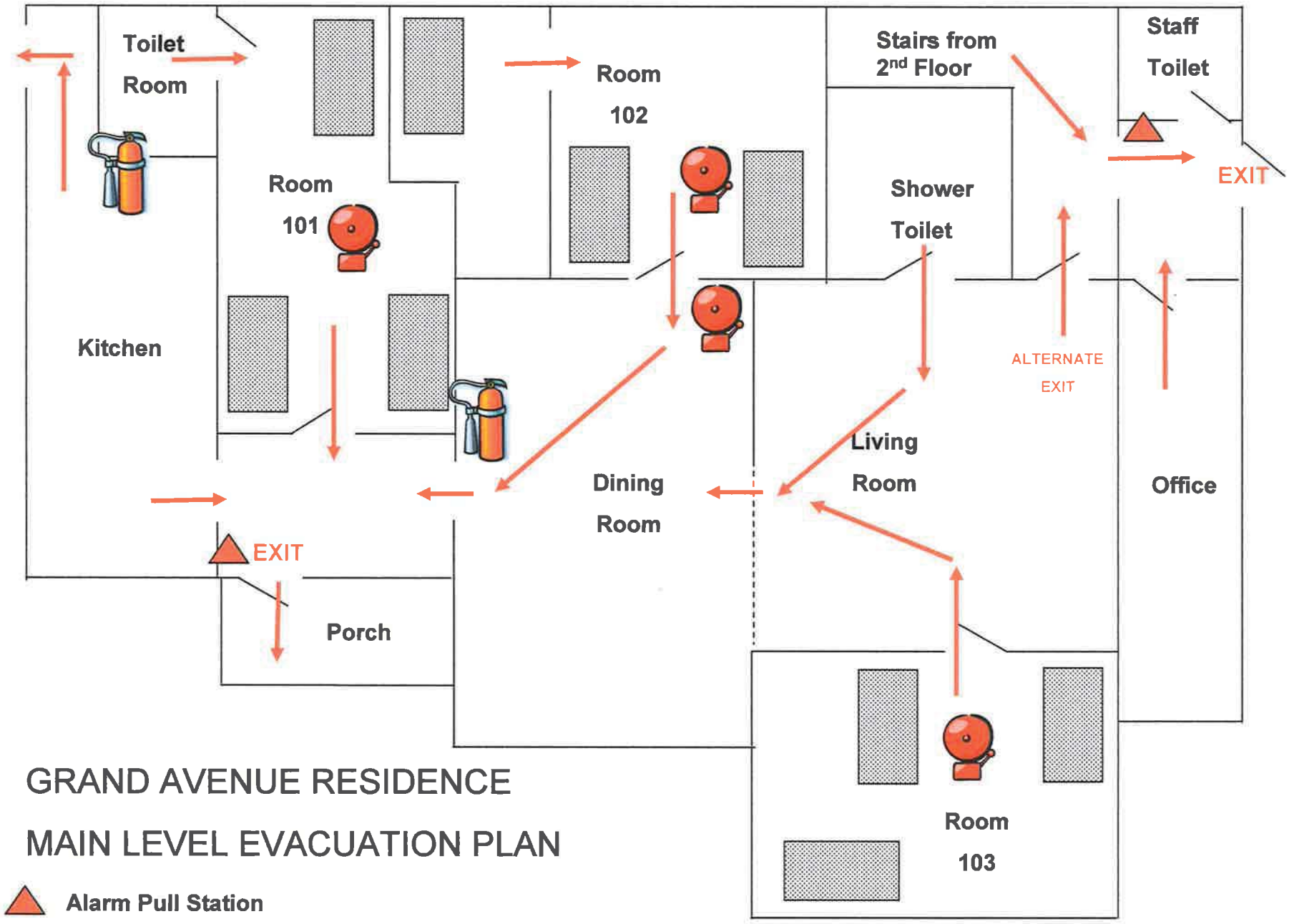
TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

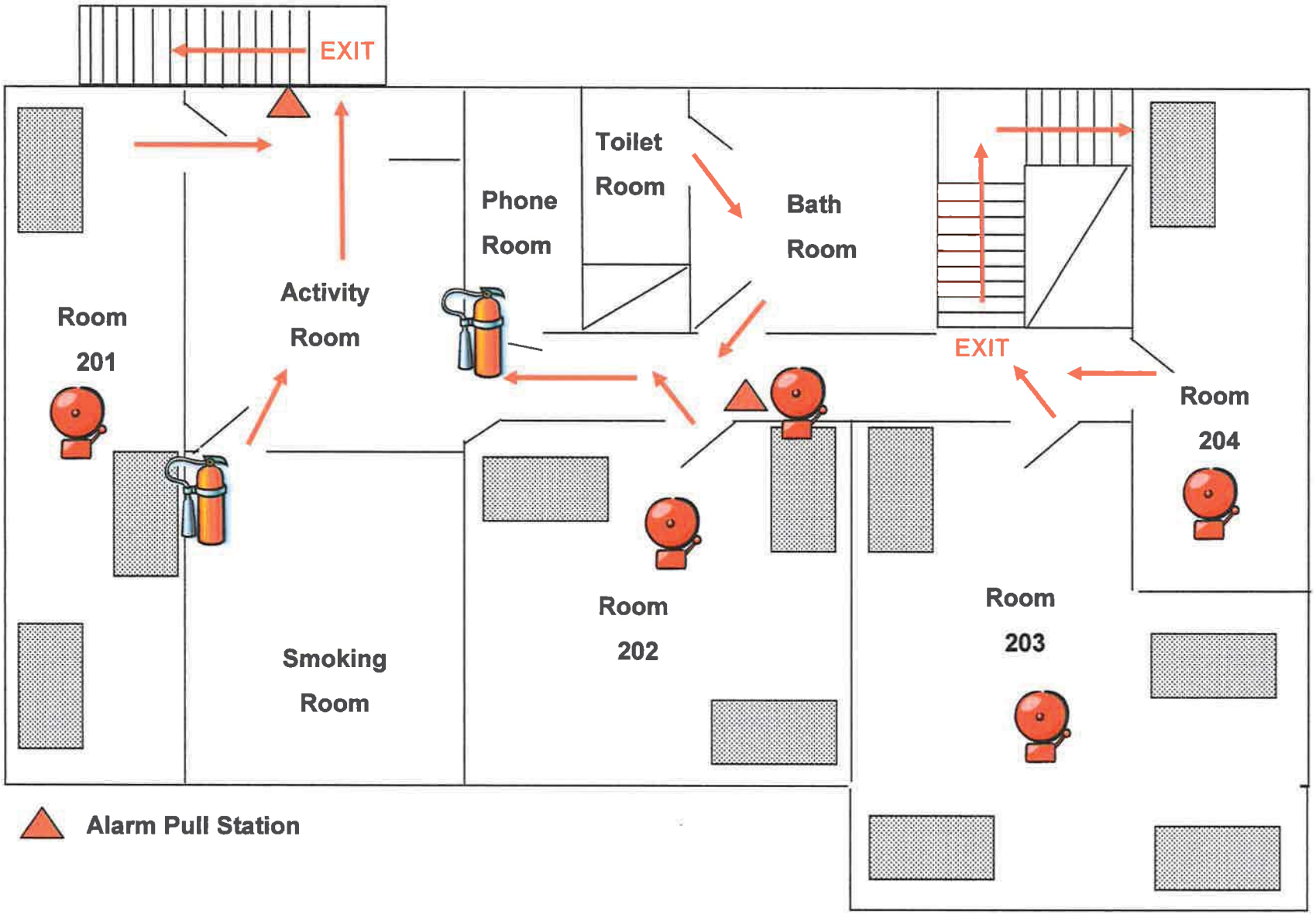
1. Construction [Score: -7]:
   The building was assigned a Type V(000) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Interior finish in spaces that could be considered part of a corridor was plaster, acoustical tile and wood paneling. Based on interview with the administrator, all acoustical tile and wood paneling was treated with Flame Control No. 20-20A Flat Latex Intumescent Fire Retardant Paint and/or Flame Control No. 40-40A Low Gloss Latex Fire Resistant Coating to achieve a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Interior finish was found to consist of plaster, acoustical tile and wood paneling. Based on interview with the administrator, all acoustical tile and wood paneling was treated with Flame Control No. 20-20A Flat Latex Intumescent Fire Retardant Paint and/or Flame Control No. 40-40A Low Gloss Latex Fire Resistant Coating to achieve a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: 0]:
   Corridor walls are constructed of ½-inch thick plaster on wood lath on both sides of wood studs, which likely provides a fire resistance of at least ½-hour. However, a 36" x 60" plexi-glass vision panel was found in the wall between the smoking room and activity room, which serves as part of the corridor/exit system.

5. Doors to Corridor [Score: 0]:
   Corridor doors were found to be of wood panel, glass panel and solid wood core construction.
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. The building measures approximately 60 feet in length. Due to a lack of complying means of egress, Parameter 10 was scored at -8.
7. Vertical Openings [Score: 0]:
   A 1¾-inch-thick solid wood automatic-closing door in a wood frame was found at the bottom of the stairs from this level.
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]:
    This score was assigned for the following reasons:
    - The front (east) stair enclosure serving this level currently provides 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 front (east) stairway discharges onto first floor, which does not meet the requirements of NFPA 101(00), Sec. 7.7.2 (the first floor is not separated from the basement by minimum 1-hour fire-rated construction).
    - Three of the four resident room doors were found to measure between 27½ and 31 inches in clear width and, therefore, could not be credited as an egress route [see NFPA 101A(01), Sec. 4.6.10.3.2].
    - There is a 29-inch clear width door providing access to a 41-inch clear width fire escape from the activity room; however, fire escapes are not an acceptable means of egress from health care facilities [see NFPA 101(00), Sec. 19.2.2.1]. Access to the fire escape is through the Activity Room. NFPA 101(00), Sec. 19.2.5.9 requires that corridors provide access to not less than two approved exits without passing through any intervening rooms or spaces other than corridors or lobbies.
    - The corridor is only 46 inches in clear width instead of the 48 inches required by the code.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations were found in the corridor (between Resident Rooms 202 and 203) and adjacent to the door to the fire escape. The fire alarm system is monitored by Trans-Alarm.
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 corridor and activity room. This parameter was scored as "Corridor Only" smoke detection.
13. Automatic Sprinklers [Score: +10]:
    The building is protected by a supervised, dry-pipe automatic sprinkler system consisting of quick-response sprinklers.

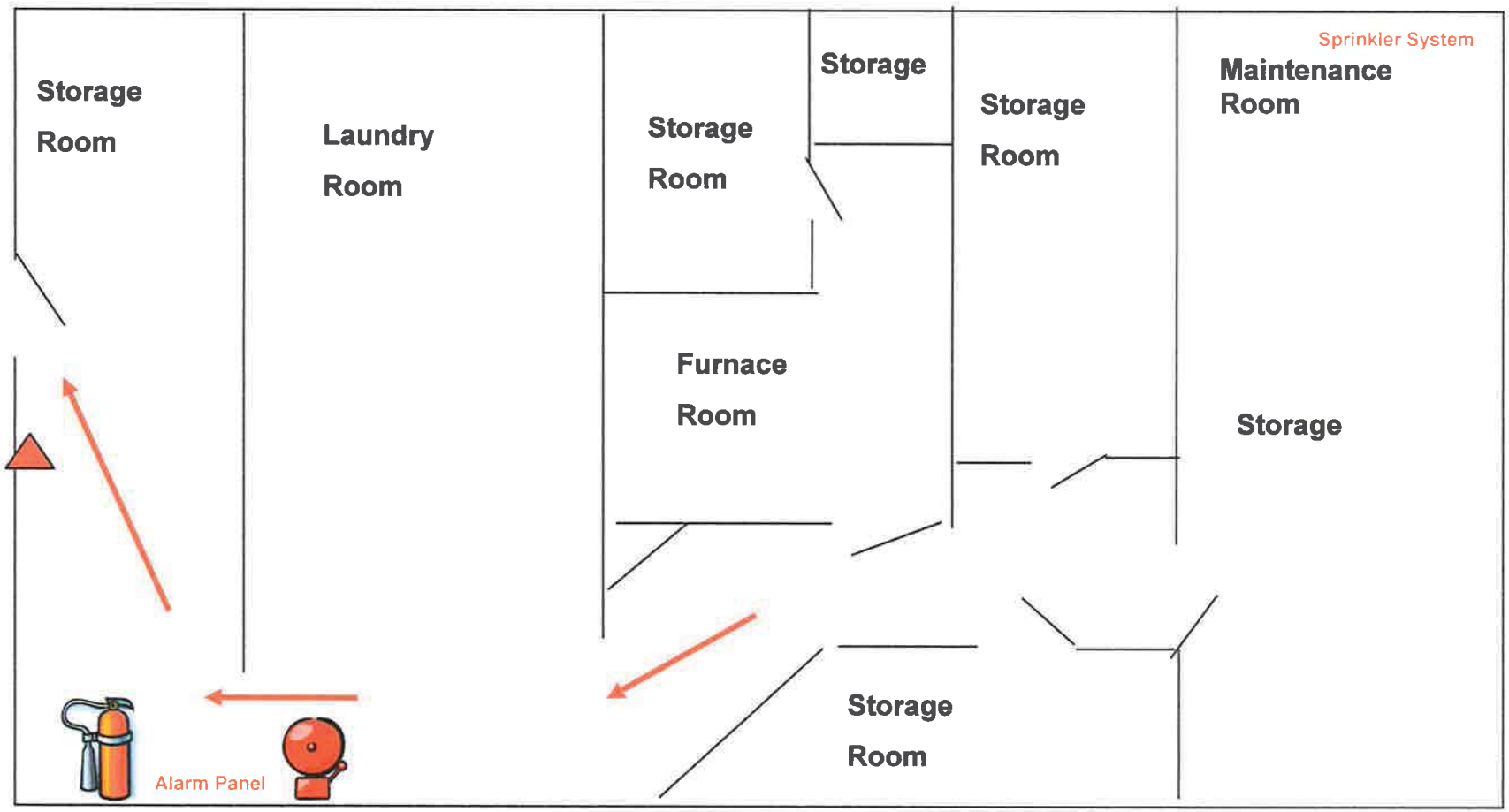
* * * * * * * * * * * * *

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 0845 hours and 1115 hours on 12/19/12. Any changes in those conditions after that date could affect those scores and values, either positively or negatively. Again, based on this evaluation, Grand Avenue Rest Home 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.*


Toilet
Room
Room
101
Kitchen
Room
102
Stairs from
2nd Floor
Staff
Toilet
EXIT
Shower
Toilet
ALTERNATE
EXIT
Living
Room
Office
Dining
Room
EXIT
Porch
Room
103
GRAND AVENUE RESIDENCE
MAIN LEVEL EVACUATION PLAN
Alarm Pull Station



GRAND AVENUE RESIDENCE - 2ND FLOOR EVACUATION PLAN



GRAND AVENUE RESIDENCE - BASEMENT EVACUATION PLAN