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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: J9DI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00780

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/30/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Facility's request for continuing waivers involving tags 0354 (RN 8 hrs 7 days/week) and 0458 (Bedrooms measure at least 70 sq ft) is recommended.

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Supervisor 03/31/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/31/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-E507

March 31, 2015

Ms. Catherine Scoville, Administrator
Southside Care Center
2644 Aldrich Avenue South
Minneapolis, Minnesota 55408

Dear Ms. Scoville:

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

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

Effective March 30, 2015 the above facility is certified for:

17 - Nursing Facility II Beds

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

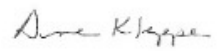
Your request for waiver of tags 0354 and 0458 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation. If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiencies or renew your request for waiver in order to continue your participation in the Medicare and Medicaid Program.

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

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

Please contact me if you have any questions.

Sincerely,



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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 31, 2015

Ms. Catherine Scoville, Administrator
Southside Care Center
2644 Aldrich Avenue South
Minneapolis, Minnesota 55408

RE: Project Number SE507024

Dear Ms. Scoville:

On February 27, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 13, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

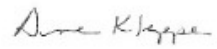
On March 30, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 26, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 13, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 30, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 13, 2015, effective March 30, 2015 and therefore remedies outlined in our letter to you dated February 27, 2015, will not be imposed.

Your request for a continuing waiver involving the deficiencies cited under 0354 and 0458 at the time of the February 13, 2015 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Please contact me if you have any questions about this letter.

Sincerely,



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

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E507	A. Building B. Wing	3/30/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **03/11/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **03/11/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **03/11/2015**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **03/11/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **03/30/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **03/16/2015**
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	GD/AK	03/31/2015	18623	03/30/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/13/2015			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E507	A. Building B. Wing **01 - MAIN BUILDING 01**	3/26/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **02/20/2015**	ID Prefix	Correction Completed **02/20/2015**	ID Prefix	Correction Completed **02/20/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0012		LSC K0033		LSC K0034	
ID Prefix	Correction Completed **02/20/2015**	ID Prefix	Correction Completed **02/20/2015**	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. #	
LSC K0039		LSC K0147		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	03/31/2015	28120	03/26/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/12/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: J9DI

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/13/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Facility's request for continuing waivers involving tags 0354 (RN 8 hrs 7 days/week) and 0458 (Bedrooms measure at least 70 sq ft) is recommended.

17. SURVEYOR SIGNATURE — Date:
Kathy Sass, HPR Dietary Specialist — 03/19/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Anne Kleppe, Enforcement Specialist — 03/30/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
3/31/15 (L33)

DETERMINATION APPROVAL

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

020499

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

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8. Full Survey After Complaint

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(L9)

6. DATE OF SURVEY **02/13/2015** (L34)

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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)

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Anne Kleppe, Enforcement Specialist 03/30/2015 (L20)

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

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30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 5827

February 27, 2015

Ms. Catherine Scoville, Administrator
Southside Care Center
2644 Aldrich Avenue South
Minneapolis, Minnesota 55408

RE: Project Number SE507024

Dear Ms. Scoville:

On February 13, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

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

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 25, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 25, 2015 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 13, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 13, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	02/13/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	RECEIVED MAR 16 2015 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	Accepted 3-19-15 Jenni Dahlen	3/14/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Catherine Scoville	Administrator	3/12/15

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

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F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure alleged violations involving resident to resident altercations and injuries of unknown origin were adequately investigated and/or immediately reported to the administrator and state agency for 5 of 5 residents (R9, R4, R10, R16, R12) incidents reviewed. Findings include: R9 inappropriately fondled R4, the facility failed to immediately report to the administrator and state agency (SA) and did not submit the investigative report within five days to the SA. R9 had a diagnosis of paranoid schizophrenia and bipolar disorder listed on the physician orders dated 12/16/14. The quarterly Minimum Data Set (MDS) dated 12/3/14, indicated R9 was cognitively intact. The Care Area Assessments (CAA's) were requested but not provided. R9's current plan of care dated 1/15/15, identified	F 225		

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F 225	Continued From page 2 R9 had impaired cognitive function or impaired thought processes due to paranoid schizophrenia, bipolar. The Southside Care Center Individual Abuse Prevention Plan Susceptibility To Abuse Checklist dated 3/25/14 indicated R9 exhibited poor personal hygiene and psychotic behavior such as hallucinations or delusions. R4 had a diagnosis of schizoaffective bipolar disorder, post-traumatic stress disorder and anxiety listed on the physician orders dated 12/3/14. The MDS dated 12/9/14, indicated R4 was cognitively intact. The CAA's were requested but not provided. R4's current plan of care dated 12/16/14, identified R4 had potential to be verbally aggressive due to diagnosis of schizoaffective bipolar disorder. The Southside Care Center Individual Abuse Prevention Plan Susceptibility To Abuse Checklist dated 4/22/14 indicated R4 had potential for verbally threatening others, displaying rage and poor impulse control, exhibited psychotic behavior such as hallucinations or delusion and would perseverate with loud vocalizations. An incident report dated 6/17/14, indicated R9 and R4 were in the upstairs hallway at 5:00 p.m. on 6/16/14. The incident report indicated R9 asked R4 about her lipstick, then took her hand and put it on his groin, kissed her, made some shaking movements (like dancing) in front of her. R4 told him to stop and moved away. Review of the investigative report indicated the resident to resident abuse was not submitted to the SA until 6/17/14, one day after the incident	F 225		

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F 225	Continued From page 3 occurred. The investigative report was submitted to the SA on 6/24/14, seven days after the incident occurred. During an interview on 2/13/15, at 10:01 a.m. the program director (PD) stated he notified the administrator and completed the incident report the day after the incident occurred, but should have reported the incident immediately. During an interview on 2/13/15, at 10:01 a.m. the administrator stated the PD notified her on 6/17/14, "within 24 hours." Administrator verified that she and the SA should be notified immediately. Administrator verified the investigative report was not submitted within five days to the SA. Although the facility was aware of the resident to resident sexual abuse between R9 and R4, they did not report to the administrator and SA immediately. R12 was found on the street intoxicated with injuries of unknown origin. The facility failed to immediately report to the SA. R12 had diagnosis of traumatic brain injury, chronic alcohol abuse, depression listed on the physician orders dated 12/5/14. The quarterly MDS dated 1/21/15 indicated R12 was cognitively intact. The CCA's dated 10/27/13 indicated that R12 has diagnoses of mild intellectual disability with depression, abuses alcohol causing decision making to be very poor. R12's current plan of care dated 2/10/14, identified R12 had an increased potential for falls	F 225		

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F 225	Continued From page 4 and injury due to alcohol intake and independence. An incident report dated 6/3/14, indicated on 6/2/14 at approximately 10:00 p.m. R12 was found on the street sitting by two neighbors with a small lump to her right temple, scrapes on right elbow and left lower leg and urine soaked pants. R12 stated "I already fell before." The report indicated the probable causal factor was drinking alcohol. Review of the investigative report indicated the injuries of unknown origin was not submitted to the SA until 6/5/14, three days after the incident occurred. During an interview on 2/13/15, at 10:10 a.m. the PD stated he notified the previous administrator, however did not report immediately to the SA. During an interview on 2/13/15, at 10:10 a.m. the administrator stated she was not employed on the day of the incident, but when she started employment on 6/9/14 completed the investigation. Administrator verified the report was not and should have been reported immediately to the SA. Although the facility was aware of the injuries of unknown origin for R12, they did not notify the SA immediately. R9 feared for his safety in the facility after stating he was threatened with a knife by R10, the facility failed to thoroughly investigate and immediately report to the administrator and SA.	F 225	F225 Resident R4 has a diagnosis of latent unspecified schizophrenia and resided in room 205-2. R4 moved from Southside as of 2/13/15. Resident R9 has a diagnosis of Unspecified Schizophrenia and bipolar disorder and resides in room 204-2. R9's Care plan was updated on 3/11/15 to include the following non pharmacological interventions: reading of interest, take a walk and listening to his religious music. R10 has a diagnosis of schizophrenia with anxiety and resides in room 205-3. Resident R10's care plan was updated on 2/16/15 to include leading a book club. R12 has a diagnosis of depressive disorder, acute alcohol intoxication and resides in room 102-4. Residents care plan was updated 3/11/15 to include the following non pharmacological interventions: Encouragement to participate in daily exercise with activity program and watch TV in her room for quiet time.	

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

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F 225	Continued From page 5 During record review for R9 on 2/11/15, at 10:30 a.m. a chart document was discovered from the Native American Community Clinic Counseling Services dated 8/13/14. The chart document indicated R9 was in a manic and paranoid state, and preoccupied with "demonic activity" taking place at his residence. R9 reported he feared for his safety after a co-resident threatened him with a knife two days ago in retaliation for him kissing her roommate which was unwelcomed. The document indicated that they notified the facility to discuss safety plan and coordinate care. R10 had a diagnosis of schizoaffective bipolar disorder listed on the physician's order dated 12/3/14. The quarterly MDS dated 12/22/14 indicated R10 was cognitively intact. The CCA's were requested but not provided. The Southside Care Center Individual Abuse Prevention Plan Susceptibility To Abuse Checklist dated 6/19/14 indicated R10 had potential to exhibit self-injurious behavior or self-inflicted abuse by avoiding necessary medications and had had poor decision making skills. During an interview on 2/11/15, at 2:19 p.m. PD no one had threatened R9 with a knife. PD stated on 8/6/14, R10 was cutting a cucumber with a knife and R9 thought she was threatening him. PD stated he was aware of the 8/13/14 clinic chart document and that R9 had feared for his safety. PD verified he did not immediately notify the administrator or SA. During an interview on 2/11/15, at 3:10 p.m. Administrator stated she was aware of R9 feeling threatened when R10 was cutting up a cucumber with a knife on 8/6/14 but was not told until 8/7/14. Administrator stated she conducted	F 225	Resident R16 has a diagnosis of unspecified schizophrenia and anxiety and resides in room 204-1. The residents care plan was updated to include encouragement to participate in the daily activity program and to invite friends and family to visit. Charted care plans in the past have not highlighted updates. Southside will now highlight all changes in care plan to draw attention to updated information. MDS and care plans transitioned from JRaven to PointClickCare on 12/1/14 for increased accuracy and timeliness. Southside vulnerable adult Abuse prevention policy was updated and Staff training was completed On 2/16/15. Administrator spoke Staff were instructed to immediately report all incidents to the Administrator, DON and Program Director. Procedure was updated to include immediately completing an incident report.	

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F 225	Continued From page 6 interviews, they discussed the incident with the interdisciplinary team and decided to remove and lock up all sharp knives after the cooks leave at 3:00 p.m. everyday and thought an incident and state agency report was made. Administrator stated she was not aware of the clinic chart document and verified that there should have been an incident report and report to the SA for both the 8/6/14 and 8/13/14 incidents reported by R9, "I would have thought that would have been done because the police were called." Although the facility was aware R9 feared for his safety due to a possible resident to resident altercation, the facility did not thoroughly investigate and notify the administrator and SA immediately. R9 threatened R16 with an aluminum water bottle, the facility failed to thoroughly investigate and immediately report to the administrator and SA. Review of a progress note on 8/16/14, at 1130 a.m. indicated R9 was very aggressive and threatening to hit his roommate with an aluminum water bottle. Police were called and R9 was taken to crisis at Hennepin County hospital. Review of a progress note on 8/16/14, at 12:30 p.m. indicated the program director was notified that R9 was in the crisis center, the director will notify the director of nursing (DON) and administrator of behaviors. Review of a progress note on 8/16/14, at 3:20 p.m. indicated the crisis center called and stated they were sending R9 back because they could	F 225	Incident regarding R4 and R9: Police were called and they Spoke to R9 and determined He wasn't a threat. The police Left without giving a report number and told Program Director that R9 was not a threat. Administrator met with R4 and asked if R4 felt safe and was told yes. R4 has a cell phone and put front desk in quick dial for safety. 2 hr checks are regularly completed from 10:30pm to 6am. Administrator did regular check in's with R4 to ensure she continued to feel safe. R9 was evaluated by his psychiatrist And made medication changes. Incident with R9 telling clinic he felt unsafe: Administrator instructed Program Director that all medical records coming from outside resources must be seen by the DON. All medical record changes will be discussed at the interdisciplinary meeting.	

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F 225	Continued From page 7 not hold him because he came in voluntarily. R16 had diagnosis of paranoid schizophrenia listed on the physician orders dated December 8, 2014. The quarterly MDS dated 12/16/14 indicated R16 was cognitively intact. The CCA's were requested but not provided. The Southside Care Center Individual Abuse Prevention Plan Susceptibility To Abuse Checklist dated 5/20/14 indicated R16 exhibited psychotic behavior such as hallucinations and had occasional confusion. During an interview on 2/11/15, at 3:10 p.m. the PD verified that "this one should have been reported." PD stated the staff did call him but "I did not call the administrator." During an interview on 2/11/15, at 3:10 p.m. the administrator stated "this is the first I have heard of this." PD stated she was not aware that this situation was going on. Although the facility was aware of the resident to resident altercation between R9 and R16, they did not notify the administrator and SA immediately. The facility's Abuse Prevention Plan dated 2010, indicated examples of abuse and neglect to be reported include resident to resident acts which cause serious pain, suffering, injury or hurt while on facility premises or in the community, any physical injury sustained by a resident which is not explained by the resident history of the injury, incidents involving unwelcome sexual contact between residents. OHFC (Office of Health Facility Complaints) - Reportable Events indicated, "Southside Care Center staff when made aware of a reportable event will complete	F 225	Incident with R9 and R16: Administrator and Program Director met with R9 and R16 On 3/11/15. R9 was asked if he felt safe in his room. He stated, "yes". R16 was asked if he felt safe in his room and he stated, "yes". Administrator And Program Director let both of them know that if at any time either one felt that they were in any kind of threat, they should immediately pull their call light And staff would be there to help. They both agreed to use their call light. Two hour checks are completed from 10:30pm to 6am throughout the building. Incident with R12: The Administrator started working for Southside. on 6/9/15, which was 7 days After the incident occurred. Administrator spoke to staff on 2/16/15 on immediately reporting all incidents to the Administrator, DON and Program Director. VA policy and procedure Was updated to include completing an incident report immediately following an incident.	

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F 225	Continued From page 8 the appropriate Incident Report and notify the Administrator immediately and all Reportable Events must be reported to OHFC within 24 hours of the incident's discovery. The investigative report must be submitted within 5 working days." The facility's Abuse Prevention Plan policy lacked clear instruction to report allegations of abuse, neglect and mistreatment immediately to the other officials in accordance with State law through established procedures (which included the office of health facility complaints-OHFC).	F 225	During the admission process The Program Director will discuss any behavior concerns of potential residents with the DON and Administrator to avoid future concerns. Southside vulnerable adult abuse prevention policy was updated and staff training was completed on 2/16/15. Administrator educated staff on immediately reporting all incidents to the Administrator, DON and Program Director. Procedure was updated to include immediately completing an incident report. Administrator/designee will report incident to CEP and OHFC. All incident reports will be discussed at weekly interdisciplinary meetings, care plans will be updated and again discussed during quarterly QA meetings. Administrator to monitor.	03/11/15
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement the abuse prevention policy for notifying the State Agency (SA) and administrator immediately regarding resident to resident altercations and injuries of unknown origin for 5 of 5 residents (R9, R4, R10, R16, R12) whose incidents were reviewed. Findings include: The [Facility] Abuse Prevention Plan dated 2010, indicated examples of abuse and neglect to be reported include resident to resident acts which cause serious pain, suffering, injury or hurt while	F 226		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 9 on facility premises or in the community, any physical injury sustained by a resident which is not explained by the resident history of the injury, incidents involving unwelcome sexual contact between residents. OHFC (Office of Health Facility Complaints) - Reportable Events indicated, "Southside Care Center staff when made aware of a reportable event will complete the appropriate Incident Report and notify the Administrator immediately and all Reportable Events must be reported to OHFC within 24 hours of the incident's discovery. The investigative report must be submitted within 5 working days." The facility's Abuse Prevention Plan policy lacked clear instruction to report allegations of abuse, neglect and mistreatment immediately to the other officials in accordance with State law through established procedures (which included the office of health facility complaints-OHFC). R9 inappropriately fondled R4, the facility failed to immediately report to the administrator and state agency (SA) and did not submit the investigative report within five days to the SA. R9 had a diagnosis of paranoid schizophrenia and bipolar disorder listed on the physician orders dated 12/16/14. The quarterly Minimum Data Set (MDS) dated 12/3/14, indicated R9 was cognitively intact. The Care Area Assessments (CAA's) were requested but not provided. R9's current plan of care dated 1/15/15, identified R9 had impaired cognitive function or impaired thought processes due to paranoid schizophrenia, bipolar. The Southside Care Center Individual Abuse Prevention Plan	F 226		

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F 226	Continued From page 10 Susceptibility To Abuse Checklist dated 3/25/14 indicated R9 exhibited poor personal hygiene and psychotic behavior such as hallucinations or delusions. R4 had a diagnosis of schizoaffective bipolar disorder, post-traumatic stress disorder and anxiety listed on the physician orders dated 12/3/14. The MDS dated 12/9/14, indicated R4 was cognitively intact. The CAA's were requested but not provided. R4's current plan of care dated 12/16/14, identified R4 had potential to be verbally aggressive due to diagnosis of schizoaffective bipolar disorder. The Southside Care Center Individual Abuse Prevention Plan Susceptibility To Abuse Checklist dated 4/22/14 indicated R4 had potential for verbally threatening others, displaying rage and poor impulse control, exhibited psychotic behavior such as hallucinations or delusion and would perseverate with loud vocalizations. An incident report dated 6/17/14, indicated R9 and R4 were in the upstairs hallway at 5:00 p.m. on 6/16/14. The incident report indicated R9 asked R4 about her lipstick, then took her hand and put it on his groin, kissed her, made some shaking movements (like dancing) in front of her. R4 told him to stop and moved away. Review of the investigative report indicated the resident to resident abuse was not submitted to the SA until 6/17/14, one day after the incident occurred. The investigative report was submitted to the SA on 6/24/14, seven days after the incident occurred.	F 226		

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F 226	Continued From page 11 During an interview on 2/13/15, at 10:01 a.m. the program director (PD) stated he notified the administrator and completed the incident report the day after the incident occurred, but should have reported the incident immediately. During an interview on 2/13/15, at 10:01 a.m. the administrator stated the PD notified her on 6/17/14, "within 24 hours." Administrator verified that she and the SA should be notified immediately. Administrator verified the investigative report was not submitted within five days to the SA. Although the facility was aware of the resident to resident sexual abuse between R9 and R4, they did not report to the administrator and SA immediately. R12 was found on the street intoxicated with injuries of unknown origin. The facility failed to immediately report to the SA. R12 had diagnosis of traumatic brain injury, chronic alcohol abuse, depression listed on the physician orders dated 12/5/14. The quarterly MDS dated 1/21/15 indicated R12 was cognitively intact. The CCA's dated 10/27/13 indicated that R12 has diagnoses of mild intellectual disability with depression, abuses alcohol causing decision making to be very poor. R12's current plan of care dated 2/10/14, identified R12 had an increased potential for falls and injury due to alcohol intake and independence. An incident report dated 6/3/14, indicated on	F 226	Resident R4 has a diagnosis of latent unspecified schizophrenia and resided in room 205-2. R4 moved from Southside as of 2/13/15. Resident R9 has a diagnosis of unspecified Schizophrenia and bipolar disorder and resides in Room 204-2. R9's care plan was updated on 3/11/15 to include the following non pharmacological interventions: reading of interest, take a walk and listening to his religious music. R10 has a diagnosis of schizophrenia with anxiety and resides in room 205-3. The resident's care plan was updated on 2/16/15 to include leading a book club. R12 has a diagnosis of depressive disorder, acute alcohol intoxication And resides in room 102-4. Residents care plan was updated 3/11/15 to include the following non pharmacological interventions: Encouragement to participate in daily exercise with activity program and watch TV in her room to calm down.	

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F 226	Continued From page 12 6/2/14 at approximately 10:00 p.m. R12 was found on the street sitting by two neighbors with a small lump to her right temple, scrapes on right elbow and left lower leg and urine soaked pants. R12 stated "I already fell before." The report indicated the probable causal factor was drinking alcohol. Review of the investigative report indicated the injuries of unknown origin was not submitted to the SA until 6/5/14, three days after the incident occurred. During an interview on 2/13/15, at 10:10 a.m. the PD stated he notified the previous administrator, however did not report immediately to the SA. During an interview on 2/13/15, at 10:10 a.m. the administrator stated she was not employed on the day of the incident, but when she started employment on 6/9/14 completed the investigation. Administrator verified the report was not and should have been reported immediately to the SA. Although the facility was aware of the injuries of unknown origin for R12, they did not notify the SA immediately. R9 feared for his safety in the facility after stating he was threatened with a knife by R10, the facility failed to thoroughly investigate and immediately report to the administrator and SA. During record review for R9 on 2/11/15, at 10:30 a.m. a chart document was discovered from the Native American Community Clinic Counseling Services dated 8/13/14. The chart document	F 226	Resident R16 has a diagnosis of unspecified schizophrenia and anxiety and resides in room 204-1. The residents care plan was updated to include encouragement to participate in the daily activity program and to invite friends and family to visit. Charted care plans in the past have not highlighted updates. Southside will now highlight all changes in care plan to draw attention to updated information. MDS and care plans transitioned from JRaven to PointClickCare for increased accuracy and due date adherence. Southside Vulnerable Adult Abuse prevention policy was updated and Staff training was completed on 2/16/15. Administrator spoke to staff about immediately reporting all incidents To the Administrator, DON and Program Director. Procedure was Updated to include immediately completing an incident report.	

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F 226	Continued From page 13 indicated R9 was in a manic and paranoid state, and preoccupied with "demonic activity" taking place at his residence. R9 reported he feared for his safety after a co-resident threatened him with a knife two days ago in retaliation for him kissing her roommate which was unwelcomed. The document indicated that they notified the facility to discuss safety plan and coordinate care. R10 had a diagnosis of schizoaffective bipolar disorder listed on the physician's order dated 12/3/14. The quarterly MDS dated 12/22/14 indicated R10 was cognitively intact. The CCA's were requested but not provided. The Southside Care Center Individual Abuse Prevention Plan Susceptibility To Abuse Checklist dated 6/19/14 indicated R10 had potential to exhibit self-injurious behavior or self-inflicted abuse by avoiding necessary medications and had had poor decision making skills. During an interview on 2/11/15, at 2:19 p.m. PD no one had threatened R9 with a knife. PD stated on 8/6/14, R10 was cutting a cucumber with a knife and R9 thought she was threatening him. PD stated he was aware of the 8/13/14 clinic chart document and that R9 had feared for his safety. PD verified he did not immediately notify the administrator or SA. During an interview on 2/11/15, at 3:10 p.m. Administrator stated she was aware of R9 feeling threatened when R10 was cutting up a cucumber with a knife on 8/6/14 but was not told until 8/7/14. Administrator stated she conducted interviews, they discussed the incident with the interdisciplinary team and decided to remove and lock up all sharp knives after the cooks leave at 3:00 p.m. everyday and thought an incident and	F 226	Incident with R4 and R9: Police were called and they Spoke to R9 and determined He wasn't a threat. The police left without giving a report number and told Program Director that R9 was not a threat. Administrator met with R4 and asked if R4 felt safe and was told yes. R4 has a cell phone and put front desk in quick dial for safety. 2 hr checks are completed between 10:30pm and 6am. Administrator did regular check in's with R4 to ensure she continued to feel safe. R9 was evaluated by his psychiatrist and changes were made to medications. Incident with R9 telling clinic he felt unsafe: Administrator instructed Program Director that all medical records coming from outside resources must be seen by the DON. All record changes will be discussed at the interdisciplinary meeting and quarterly QA meetings.	

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F 226	Continued From page 14 state agency report was made. Administrator stated she was not aware of the clinic chart document and verified that there should have been an incident report and report to the SA for both the 8/6/14 and 8/13/14 incidents reported by R9, "I would have thought that would have been done because the police were called." Although the facility was aware R9 feared for his safety due to a possible resident to resident altercation, the facility did not thoroughly investigate and notify the administrator and SA immediately. R9 threatened R16 with an aluminum water bottle, the facility failed to thoroughly investigate and immediately report to the administrator and SA. Review of a progress note on 8/16/14, at 1130 a.m. indicated R9 was very aggressive and threatening to hit his roommate with an aluminum water bottle. Police were called and R9 was taken to crisis at Hennepin County hospital. Review of a progress note on 8/16/14, at 12:30 p.m. indicated the program director was notified that R9 was in the crisis center, the director will notify the director of nursing (DON) and administrator of behaviors. Review of a progress note on 8/16/14, at 3:20 p.m. indicated the crisis center called and stated they were sending R9 back because they could not hold him because he came in voluntarily. R16 had diagnosis of paranoid schizophrenia listed on the physician orders dated December 8,	F 226	Incident with R9 and R16: Administrator and Program Director met with R9 and R16 On 3/11/15. R9 was asked if he felt safe in his room. He stated, "yes". R16 was asked if he felt safe in his room and he stated, "yes". Administrator And Program Director let both of them know that if at any time either one felt that they were in any kind of threat, they should immediately pull their call light and staff would be there to help. They both agreed to use their call light. Two hour checks are completed from 10:30pm to 6am Incident with R12: The Administrator started Working for Southside on 6/9/15, which was 7 days After the incident occurred. Administrator spoke To staff on 2/16/15 on immediately reporting all incidents to the Administrator, DON and Program Director. VA policy and procedure updated to include completing an incident report immediately following an incident.	

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F 226	Continued From page 15 2014. The quarterly MDS dated 12/16/14 indicated R16 was cognitively intact. The CCA's were requested but not provided. The Southside Care Center Individual Abuse Prevention Plan Susceptibility To Abuse Checklist dated 5/20/14 indicated R16 exhibited psychotic behavior such as hallucinations and had occasional confusion. During an interview on 2/11/15, at 3:10 p.m. the PD verified that "this one should have been reported." PD stated the staff did call him but "I did not call the administrator." During an interview on 2/11/15, at 3:10 p.m. the administrator stated "this is the first I have heard of this." PD stated she was not aware that this situation was going on. Although the facility was aware of the resident to resident altercation between R9 and R16, they did not notify the administrator and SA immediately.	F 226	226 During the admission process the Program Director will discuss behavior concerns of potential residents with the DON and Administrator. Southside vulnerable adult abuse prevention policy was updated and staff training completed on 2/16/15. Administrator educated staff on immediately reporting all incidents to the Administrator, DON and Program Director. Procedure was updated to include staff completing an incident report. Immediately following an incident. Administrator or designee will report incident to CEP and OHFC. All incident reports will be discussed at weekly interdisciplinary meetings, care plans will be updated and again discussed during quarterly QA meetings. Administrator to monitor.	03/11/15
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	F 280		

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F 280	Continued From page 16 and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop the care plan for 1 of 5 residents (R9) in the sample reviewed for unnecessary medication use to include non-pharmacological interventions and medications. Findings include: R9 was admitted to the facility on 8/31/12, per the Admission Record with documented diagnoses on the 2/15, Medication Administration Record (MAR) of paranoid schizophrenia, bipolar personality disorder, DM type I uncontrolled, and obstructive sleep disorder. R9 had a physician order dated, 10/14/14, for Risperidone 1 milligram (mg) 1 tab by mouth (PO) every morning and 2 mg every evening for a diagnosis of Schizophrenia. R9 had a physician order, 7/1/14, for Seroquel 200 mg, 1 tab PO at bedtime for manic symptoms. R9 was observed during the survey on 2/10/15 and 2/11/15, and no behaviors were observed. On 2/11/15, at 8:00 a.m. R9 came down to the dining room fully dressed and a nicely groomed beard. The resident sat down at the table for	F 280	280 Resident R9 has a diagnosis of unspecified schizophrenia and bipolar disorder and resides in Room 204-2. R9's Care plan was updated on 3/11/15 to include the following non pharmacological interventions: reading of interest, take a walk and listening to his religious music. Upon admission, the resident will be interviewed for past activities interest. The Activities program will be updated when possible to include activities that the new resident would be willing to participate in. The Activities Director Will go room to room Individually encouraging each resident to participate. Southside transitioned MDS from JRaven to PointClickCare on 12/1/14. PointClickCare provides an ease to MDS and care planning which better tracks and documents resident activity and progress. All incidents and quarterly care plan meetings will be discussed during weekly interdisciplinary meetings. DON to monitor.	03/11/15

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F 280	Continued From page 17 breakfast. At 8:10 a.m. R9 was watching TV in the dining room. He was served breakfast of two slices of whole wheat toast with butter and jelly, hot cereal, milk, coffee and water. R9 was interviewed on 2/11/15, at 8:00 a.m. and stated that in the morning he felt sluggish but as the day went on he felt less sluggish. R9 was seen on 8/14/14, at the Native American Community Clinic Counseling Services (NACCCS) and at the time of the counseling session he was disheveled and was bizarre. R9 was restless, agitated and overly dramatic and negative. His mood was irritable and, anxious. His concentration was impaired by rumination, thoughts were paranoid and of a religious nature. He had poor impulse control. Comments during the visit were: " Is in a manic and paranoid state, and preoccupied with ' demonic activity ' taking place at his residence. " R9 reported fear for his safety after a co-resident threatened him with a knife two days ago in retaliation for him kissing her roommate, unwelcomed. R9 reported fear for his safety and a safety plan was discussed for R9 to stay away from the women at the facility. R9 was to use walk-in appointments should symptoms worsen. Summary: R9 came in as a walk in due to needing support with coping with stress related "witchcraft" taking place in his residence. " The resident acknowledging not being well mentally and agreed to my calling his psychiatrist. " R9 had seen his psychiatrist the day before. Problem Definition/Bipolar Disorder. -- " Depression Symptoms: depressed mood: appetite/weight disturbance: poor sleep, psychomotor agitation or retardation, low energy/fatigue, feelings of worthlessness, guilt,	F 280		

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F 280	Continued From page 18 and or shame, poor concentration/attention, recurrent thoughts of death, suicidal ideation, or thoughts of self-harm. --Mania symptoms: inflated self-esteem/grandiosity, decreased need for sleep, pressured speech, flight of ideas, distractibility, and increase in goal directed activity, excessive involvement in pleasurable activities (history of hospitalizations during this time). " Nurses Note/Progress Note dated 8/16/14, at 11:30 a.m. "Very aggressive, threatening his roommate, tried to give him a PRN [as needed] Risperdal 2 mg but refused it x 2, attempted to hit roommate with aluminum H20 bottle, I tried to take it from his hand and he acted as he was going to hit me. 911 called to evaluate for increased confusion ' aggression. ' ' -8/16/14, at 11:45 a.m. " Police here and R9 took prn. Police spoke with [R9] and roommate then took him to clinic for evaluations at a hospital. Medical information sent with police. " - 8/16/14, at 2:30 p.m. The hospital called the facility to inform the facility that R9 was sent back, because he came voluntary. The physician agreed to change Risperdal from PRN to daily. " - 8/16/14, at 4:20 p.m. R9 returned to facility via bus, ate supper, and went out for coffee. - 8/16/14, at 6:15 p.m. R9 went to his room and fell asleep. Staff went to get him up for meds and to see how he was doing at 9:00 p.m. R9 stated "Boy it's 9:00 p.m. " I'm so tired " and went back to bed. R9's MAR indicated the facility was tracking the following target behaviors: 1) physical symptoms towards others, 2) paranoid statements, increased confusion, delusions -preaches	F 280		

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F 280	Continued From page 19	F 280		

religion, speaks of witchcraft, and 3) verbal behaviors towards others. During the following months (November, December, and January) there were no physical symptoms towards others. In November there were four incidents, December there were five incidents, and in January there were six incidents of paranoid statements, increased confusion, preaching religion and speaking of witchcraft. In November there was one incident, in December zero incidents, and January zero incidents of verbal behaviors.

R9's care plan, no date, was reviewed. The director of nursing (DON) confirmed the care plan was the most current, 2/11/15, at 3:00 p.m. the care plan indicated R9 had cognitive impairment related to schizoaffective, bipolar disorder, mood disturbance, depression, mania/hypomania, refusal to take medications, treatments, and cares. The approaches/interventions included the following:
1. " Discourage use of alcohol and illegal drugs. Discuss the depressive effects of both.
2. Encourage resident to take meds as ordered and to attend all physiatrist appointments.
3. Continue to teach about depression and its impact on present/future life styles. Get verbal understanding.
4. Document behaviors and inform doctor.
5. Invite participating in all house activities.
6. Encourage independent activities such as going to the Indian Center, out with friends for coffee and cards. "

The facility's policy on Care Plans, 3/11, indicated that "A written care plan shall be developed and maintained for each resident of the facility. The purpose was "To provide a personalized plan of

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F 280	Continued From page 20 daily care based on the nature of the disability, treatments prescribed, long and short term goals, physician's orders, medications, diet and required therapies." The (DON) was interviewed on 2/11/15, at 4:30 p.m. and confirmed the care plan had not been revised to reflect current behaviors, to show non-pharmacological interventions, and physician orders for Risperdal and Seroquel. The DON confirmed she had started employment at the facility on 12/1/14, and had not an opportunity to review R9's care plan.	F 280		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and	F 334		3-11-15

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	24E507	A. BUILDING _____ B. WING _____	02/13/2015

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

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F 334	Continued From page 21 (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.	F 334		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 334	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R18) was offered and/or received pneumococcal vaccinations as recommended by Centers for Disease Control (CDC). Findings include: The Minimum Data Set (MDS) annual assessment dated 12/4/14, indicated R18 was admitted to the facility on 11/27/12. Review of R18's immunization record lacked documentation if a pneumococcal vaccination had been received, was contraindicated or refused. On 2/12/15, at 1:50 p.m. when interviewed licensed practical nurse (LPN)-A, indicated R18 had not been given a pneumococcal vaccination and further stated facility did not provide pneumococcal vaccinations for residents under age 65. Southside Care Center's infection control: pneumococcal vaccine policy dated April 2010 indicated "each resident over the age of 65 will be offered pneumococcal vaccine upon admission if resident has not previously received or booster pneumococcal vaccine if resident requires. I. Check with medical record, resident or family if vaccine is need. If unsure of pneumococcal vaccine status, offer resident a pneumococcal vaccine. Obtain consent form if vaccine is to be	F 334	F334 Review of 17 residents vaccinations concluded that all residents are now vaccinated with pneumococcal and influenza. Policy and Procedure updated To Include every admission Will be educated on and offered The pneumococcal and Influenza vaccine.	

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F 334	Continued From page 23 given. Vaccination Information Statement (VIS) is to be given prior to vaccine." The policy also lacked evidence of how the facility was going to determine pneumococcal vaccination among persons living in closed settings (e.g., nursing homes and other chronic care facilities) whether they over the age of 65 or under 65 years of age.	F 334	Staff Training completed on 3/11/15. Any concerns will Be discussed during quarterly QA meetings. Program Director to monitor.	03/11/15
F 354 SS=C	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a full time registered nurse (RN) was employed for eight consecutive hours a day, seven days per week. This had the potential to affect 17 of 17 residents in the facility Findings include: The facility received a waiver letter dated 4/29/14. Effective 3/12/14 the above facility was certified for 17 Nursing Facility beds. "Your request for	F 354	Waiver Request	

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F 354	Continued From page 24 waiver of tag 354 had been approved based on the submitted documentation. You should advise our office of any changes in staffing, services, or organization, which might affect your certification status." On 2/11/15, at 9:40 a.m. the director of nursing (DON) was interviewed and confirmed she worked 10 hours a week at the facility. The DON confirmed she started employment at the facility on 12/1/14. The DON further indicated she did a combination of DON duties and Minimum Data Set (MDS) duties. The DON stated her time was spent mostly with the MDS duties than as a DON. The DON confirmed that no further advertisement for a full time RN. There are no plans in the future for a full time DON. On 2/13/15, at 9:05 a.m. reviewed the staff scheduling for licensed personnel for the 2/2/15 through 2/15/15. The facility had licensed practical nurse (LPN) coverage. The DON was interviewed on 2/13/15, at 9:10 a.m. confirmed LPN-A also the facility's program director was in charge when he worked days, LPN-A was on the schedule for days 11 of 14 days. The remaining three day shifts was covered by RN-B for two shifts and LPN-B for one shift. During the evening shift, RN-B worked seven shifts, LPN-C three evening shifts, and trained medication aide (TMA)-A two shifts,and LPN-B two shifts. The night shift coverage was as follows: LPN-D six shifts, TMA-B was scheduled for seven shifts, LPN-C was scheduled for one shift. The DON stated that all staff on evenings report to LPN-A and then LPN-A would notify her of any issues. The DON further indicated that she was on call 24/7.	F 354		

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F 354	Continued From page 25 On 2/13/15, at 9:15 a.m. the administrator was interviewed and confirmed the DON worked part-time, approximately 10 hours a week, 20 hours a pay period. The administrator was aware since they did not have full time RN coverage they would need to request a waiver. Even though the facility had a RN who worked ten hours a week, the facility still did not have RN coverage eight consecutive hours a day, seven days a week. The administrator acknowledged there had been no advertising for a RN since the DON was hired. The owner at that time did not plan on hiring a full time DON.	F 354	see Addendum A Administrator to monitor	3/10/15
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow equipment sanitation and food storage procedures that would minimize the possibility of food borne illness. This had the potential to affect 17 of 17 residents in the facility, who were served food out of the kitchen.	F 371		3/30/15

ADDENDUM A

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

To: Gloria Derfus

From: Catherine Scoville
Administrator

RE: Addendum to Plan of Correction
F354

March 10, 2015

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

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

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

The two week nursing schedule includes:

Day shift 7-3 LPN coverage 14 days

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

Night Shift LPN coverage 10 days and TMA coverage 2 days

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

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

Please contact me if you have questions.

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F 371	Continued From page 26 Findings include: During tour on 2/9/15, at 12:00 p.m. the following sanitation problems were observed and confirmed by with Cook (C)-B. - the six burner stove/oven had a heavy buildup of black greasy substance in each of the four corners of the six stove top grates. - one window approximately 24" wide by 48" long situated above and to the left of the microwave and food preparation table had dead bugs and heavy dust buildup in the window sill and on the screen. The window was observed open and blowing cold air on the food preparation table area which at the time of tour contained an uncovered margarine container and bread that was used for sandwich preparation. - the outside front surface of the white microwave had a buildup of a brown grime/dirt substance on the inside of the door surface, on and around the outside of the handle, time pad and face of the door. The microwave was situated on the left side of the stainless steel food preparation table, under the open window. - the ceramic kitchen tile floor consisted of approximately eight by eight inch ceramic tiles. The surrounding grout around each tile in the walking area of the kitchen was black in color. The tiles in the corners of the kitchen and all wall edges had a heavy black residue buildup. There were a total of 17 tiles (four tiles in front of the sink, three in front of the refrigerator, seven in front of the stove, three in front of the dishwasher) that were cracked giving an uneven walking surface and black buildup in the cracks of	F 371		

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F 371	Continued From page 27 the tiles. - the kitchen refrigerator contained the following food items that were opened and undated: six ounce bag of apricots, seven ounce package of roast beef that was not sealed, six ounce package of ham, 64 ounce bottle of apple sauce. A four ounce bottle of ranch dressing was opened, not dated with a manufacturer expiration date of 12/29/14. During an interview on 2/9/15, at 12:05 p.m. C-B stated all food was usually dated when it was opened and that the stove top and microwave are wiped down every day but they "definitely" needed cleaning. C-B stated the window had not been cleaned since the air conditioner was taken out in October. C-B verified it needed to be cleaned and that the table to the right of the window was where all food preparation occurred. During an interview on 2/11/15, at 2:58 p.m. C-A verified the stove top burners, microwave and kitchen floor needed deep cleaning. C-A stated they clean the stove top and microwave everyday however did not have a deep clean schedule nor policy to clean equipment. C-A stated all cleaning is done by the cook that is on that day, but that no time was allotted to deep clean. During an interview on 2/12/15, at 10:32 a.m. the program director stated he puts up the cleaning schedule every month which includes daily, weekly and monthly kitchen cleaning but had no cleaning policy. During an interview on 2/12/15, at 3:05 p.m. the administrator (A) verified the stove, microwave and floor needed deep cleaning. A stated "I would	F 371	Southside Care Center has developed a deep cleaning policy and schedule. The indicated stove grates have been cleaned and will be cleaned weekly to ensure buildup does not occur. The window near the prep table will be remain closed at all time to avoid incoming air flow onto the prep table. The microwave will be wiped down daily. The damaged ceramic tiles in the kitchen will be replaced by 03/30/15 or a new floor will be installed. All undated and outdated food in the refrigerator Has been removed as of 3/11/15. Southside Care Center's Food service policy has been Updated to include proper labeling, dating and monitoring of refrigerated food. Southside has created a Daily, Weekly and monthly cleaning schedule for staff accountability to ensure that the kitchen is kept clean. Food monitoring and storage policy and procedure have been updated so the food in the refrigerator is checked on a daily basis.	

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F 371	Continued From page 28 assume that the weekly schedule was for deep cleaning too." Review of the Southside Care Center Kitchen Cleaning Schedules indicated the stove top, microwave and kitchen floor were to be cleaned daily. From November 2014 to February 2015 the schedules indicated that the stove top,microwave and kitchen floor were cleaned 29 of 30 days in November, 31 of 31 days in December, 30 of 31 days in January and six of nine days in February. Review of the Southside Care Center Food Service-Infection Control policy dated 4/1/10, indicated foods that are refrigerated are stored at or below 40 degrees however did not indicate proper labeling, dating and monitoring of refrigerated food.	F 371	Staff training on new and updated procedures of kitchen cleaning, food handling and storage was completed on 3/11/15. Concerns will be addressed during quarterly QA meetings. Administrator to monitor.	03/30/15
F 458 SS=E	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide at least 80 square feet of usable space in 1 of 6 resident bedrooms occupied by four residents (R5, R11, R12, R13). Findings include: Observation of the room occupied by R5, R11, R12, and R13 on 2/9/15, at 3:00 p.m. revealed the room contained a dresser and wardrobe for	F 458	Waiver request.	

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F 458	Continued From page 29 each resident. The usable floor space of the room was 310 square feet, which provided 77.5 square feet per resident.	F 458		
F 465 SS=F	On 2/9/15, at 6:21 p.m. R11 denied concerns with room size stating there was no problem with the size of her room. On 2/10/15, at 10:20 a.m., R12 denied any concerns with room size or accommodations. R5 and R13 declined all interviews during the survey. 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure that resident hallways, stairs, and bathrooms were maintained in a sanitary and homelike manner. This had the potential to affect all 17 residents residing at the facility. Findings include: The facility lacked a system to identify and repair environmental issues in hallways, stairs and bathrooms. On 2/13/15, at 9:00 a.m. during an environmental tour with the administrator and housekeeper the following was noted:	F 465	See Addendum B Administrator to monitor	~~3/11/15~~

ADDENDUM B

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

To: Gloria Derfus

From: Catherine Scoville
Administrator

Re: Addendum to Plan of Correction
F468

March 10, 2015

Room Size Waiver Request – F458

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

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F 465	Continued From page 30 -There were two rugs in front hallway measuring approximately three feet by eight feet observed with salt and gravel embedded in each of them. Both rugs had rubber edges on each of the four sides with one edge of each rug lifting up and both rugs were not flat to the floor. -The front and back stairs going to the second floor were observed with lint, dirt, and food crumbs scattered on various steps. In addition the upstairs second floor hall carpet was observed with lint and black and brown debris scattered on it. -The resident's second floor hall bathroom shower door was observed coated with water stains. The white tub floor mat was stained gray. The white grout along bottom of outside tub next to floor was black with debris. -The resident's first floor bathroom near office area was observed right side of vanity next to toilet had chips out of it. In addition, the heat radiator had heavy buildup of gray hanging dust between radiator cells and the shower window had no curtain covering it. -There was a detectable urine odor in first floor resident's room which had four residents (R5, R11, R12, and R13) in room, and was unable to tell where odor had been coming from. R5's annual Minimum Data Set (MDS) dated 11/14/14, identified R5 as having intact cognition and was frequently incontinent. R11's annual MDS dated 12/9/14, identified R11 as having intact cognition. R12's quarterly MDS dated 1/21/15, identified R12 as having intact cognition and was frequently incontinent. R13's quarterly MDS dated 1/7/15, identified R13 as having moderate cognition and	F 465	F465 The 2 entry way rugs with curled edges have been removed and will be replaced with rubber mats that do not have the potential to become dangerous with age. Southside has purchased	

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F 465	Continued From page 31 occasionally incontinent. In addition, there were boxes and bags stocked by the bed. -R10 indicated room was very small to accommodate belongings and wanted more light above bed. R10's MDS dated 12/22/14, identified R10 as having intact cognition. Administrator indicated additional night light would be added to room. On 2/12/15, at 9:27 a.m. housekeeper stated he cleaned bathrooms, dining room, bedrooms, made beds, swept stairs, mopped floors, vacuumed daily and if anything needed deep cleaning, licensed practical nurse (LPN)-A would schedule a company to come do it. On 2/13/15, at 9:22 a.m. housekeeper stated cleaned the best he could with radiator dust in first floor bathroom and would get vacuum attachment to collect dust caught in-between radiator cells. Administrator acknowledged the first floor bathroom window had no curtain and window was for light. In addition, stated window was not directly across from neighboring house and shower chair was not in front of window. On 2/13/15, at 9:24 a.m. when asked about rugs in front hallway with edges lifting up, housekeeper indicated it just happened, and would get new rugs today. On 2/13/15, at 11:00 a.m. administrator indicated two residents in first floor resident's room had urinary incontinence and housekeeping cleaned the room mattresses, beds and bedding daily. No odors observed in room at that time. The facility did not have a deep cleaning policy or	F 465	a new vacuum with attachments to clean the stairs. Southside will professionally cleaning all carpets on 3/16/15. The upstairs carpet will also be professionally cleaned to remove the noted stains. The carpets will be shampooed monthly. The upstairs bathroom door is being replaced with a new door. The tub floor mat replaced on 3/11/15. The tub grouting cleaned 3/13/15 and is on a weekly schedule. The radiator in the downstairs bathroom cleaned on 3/11/15 and all items have been added to a cleaning schedule. A window cover has been hung over the window in the downstairs bathroom. All carpets are scheduled to be professionally cleaned on 3/16/15 to clear the urine odor in resident room. A reading light has been installed for Resident R10. The housekeeping policy has been updated to ensure that any broken or damaged property is added as a work order for maintenance. Maintenance staff will check for work orders weekly.	

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SOUTHSIDE CARE CENTER	2644 ALDRICH AVENUE SOUTH MINNEAPOLIS, MN 55408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 32 carpet cleaning policy.	F 465	Daily walkthroughs will be completed by the Administrator or designee to ensure that any broken or damaged equipment are added to the work order log. Safety concerns will be discussed During quarterly QA meetings. Program Director to monitor.	3/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/12/2015

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, SOUTHSIDE CARE CENTER was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	POC ok w/FSES for K12, K33, K34, K39 3-18-15 KB RECEIVED MAR 18 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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.

Catherine Scoville 3/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/12/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. SOUTHSIDE CARE CENTER is a 2-story building with a full basement. The building was constructed 1909 and was determined to be of Type V(000) construction. This building is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 17 beds and had a census of 15 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:	K 012		

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STATE FIRE MARSHAL DIVISION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/12/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 012	Continued From page 2 Based on observation, this building does not meet the requirement for construction type and height. This deficient practice could affect all residents. Findings include: On facility tour between 9:30 AM and 11:00 AM on 02/12/2015, observation revealed that this 2-story, wood frame facility of Type V(000) construction does not meet the minimum construction requirements for a building of this height. This deficient practice was verified by the manager at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 012	Correction not needed. Southside Care Center Has achieved a passing FSES score (see enclosed FSES/HC). Administrator To monitor.	02/20/2015
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, the stairway enclosure of this facility does not meet the required one (1) hour fire resistive construction. This deficient	K 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/12/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 033	Continued From page 3 practice could affect all residents. Findings include: On facility tour between 9:30 AM and 11:00 AM on 02/12/2015, observation revealed that the wall of the stair enclosures are constructed of plaster on wood lath on wood studs, which does not meet minimum the requirements for this type of facility. This deficient practice was verified by the manager at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 033	Correction not needed. Southside Care Center Has achieved a passing FSES score (see enclosed FSES/HC). Administrator To monitor.	02/20/2015
K 034 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the stairwells in accordance with LSC (2000) Chapter 7.2. This deficient practice could affect all residents. Findings include: On facility tour between 9:30 AM and 11:00 AM on 02/12/2015, observation revealed that the back stairs at the rear exit are only 32" wide.	K 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/12/2015**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 034	Continued From page 4 This deficient practice was verified by the manager at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 034	Correction not needed. Southside Care Center Has achieved a passing FSES score (see enclosed FSES/HC). Administrator To monitor.	02/20/2015
K 039 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 This STANDARD is not met as evidenced by: Based on observation and interview, the second floor corridor does not meet the minimum 48" width requirement. This deficient practice could affect all residents. Findings include: During a tour of the facility between 9:30 AM and 11:00 AM on 02/12/2015, observation revealed that the first floor corridor is only 33 inches in clear width and not the 48 inches required for this type of facility. This deficient practice was verified by the manager at the time of the inspection. 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	Correction not needed. Southside Care Center Has achieved a passing FSES score (see enclosed FSES/HC). Administrator To monitor.	02/20/2015
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance	K 147		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 147	Continued From page 5 with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to comply with NFPA 70, The National Electric Code. This deficient practice could affect some residents. Findings include: On facility tour between 9:30 AM and 11:00 AM on 02/12/2015, observation revealed that there is a damaged electrical outlet in Room 203. There is a grounding prong broken off within the outlet. This deficient practice was verified by the manager at the time of the inspection.	K 147	The outlet in room 203 had a grounding prong broken within the outlet. The grounding prong was removed from the electrical outlet. The outlet was tested and found to be in proper working order. Administrator investigated and found that a staff member using the outlet accidently broke a plug to a vacuum cord in the Outlet. Training was provided To housekeeping to alert Maintenance immediately for all broken equipment and electrical outlets. Administrator to monitor.	02/20/2015

Report of Consultant FSES Findings

Southside Care Center

2644 Aldrich Avenue South

Minneapolis, MN 55408

Provider No. 24E507

Date of Survey: February 19, 2015

Prepared by:
Robert L. Imholte, President/Chief Manager
Fire Safety Resources, LLC
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Cold Spring, MN 56320
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February 20, 2015

Ms. Catherine Scoville
Administrator
Southside Care Center
2644 Aldrich Avenue South
Minneapolis, Minnesota 55408

RE: FSES at Southside Care Center

Dear Ms. Scoville:

Enclosed please find the survey information relating to the fire safety evaluation of Southside Care Center, 2644 Aldrich Avenue South in Minneapolis conducted on 02/19/15. 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*.

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

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

The following factors served as the basis for this evaluation:

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

Based on the conditions found during the 02/19/15 FSES survey, all four parameters in Table 7 of the FSES worksheets, ZONE FIRE SAFETY EQUIVALENCY EVALUATION, in all three zones evaluated were found to have a score of zero or greater. *Fire Safety Resources* finds, therefore, that Southside Care Center has achieved a passing FSES score. Should you have any questions or need additional information, please don't hesitate to get back to me.

Wishing you a safe day!

Robert L. Imholte

Robert L. Imholte,
President/Chief Manager
Fire Safety Resources, LLC

Enclosures
RLI/rli

FIRE SAFETY EVALUATION

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

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

What follows is a report on the results of a fire safety evaluation of the above-named facility that was conducted during an on-site visit to the facility between 0845 hours and 1110 hours on 02/19/15. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(01), *Guide to Alternative Approaches to Life Safety*. Based on this evaluation, Southside Care Center has achieved a passing score on the FSES.

In addition to the 02/19/15 walkthrough of the facility, the findings outlined herein are based on information provided by Ms. Catherine Scoville, Administrator, and Mr. Emmanuel Tandoh, Program Director; and a review of the Draft Statement of Deficiencies from a fire/life safety recertification survey conducted on 02/12/15.

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

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

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

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

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

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

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

All Levels – TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

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

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

- Building utilities and heating and air conditioning systems appear to be in conformance with NFPA 101(00), Sections 9.1 and 9.2.

  Surveyor Note: *A review of the Draft Statement of Deficiencies from the 02/12/15 fire/life safety recertification survey revealed that an electrical (K147) deficiency was issued because a damaged electrical outlet was found in Room 203 – observation revealed a grounding plug broken off in the outlet. Based on staff interview and observation, it was confirmed during this FSES survey that the grounding plug has been removed from the outlet in Room 203 and the outlet has been tested and found to be in proper working order.*
- No space heaters or incinerator were found.
- The facility's evacuation plan and fire drill records were reviewed and appeared to be in order.
- The facility's smoking regulations were reviewed and appeared to be in order.
- Draperies, cubicle curtains, upholstered furniture, mattresses and decorations were found to be in accordance with NFPA 101(00), Sec. 19.7.5.
- Portable fire extinguishers, EXIT signage and emergency lighting appeared to be provided and maintained in accordance with applicable requirements.

Zone 1 – Basement Level:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

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

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -7]:
   Because of exposed wood joists found in the basement ceiling, the building was assigned a Type V(000) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Interior finish in spaces that could be considered part of a corridor was plaster.
3. Interior Finish (Rooms) [Score: +3]:
   Interior finish in rooms was plaster; in some places gypsum wallboard has been added.
4. Corridor Partitions/Walls [Score: +1]:
   For purposes of this FSES, the basement level was treated as a single hazardous area consisting of multiple rooms. The wall separating the basement from the exitway was found to be constructed of plaster/gypsum wallboard on wood lath on both sides of wood studs, which likely provides a fire resistance of at least ½-hour.
5. Doors to Corridor [Score: +2]:
   For purposes of this FSES, the door at the bottom of the stairway leading from the basement was treated as a corridor door. The 90-minute fire-rated door in a wood frame was found to be self-closing.
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. The building measures approximately 70 feet in length on this level and Parameter 10 was assigned a score of -8. There is only one means of egress from this level. This results in a dead-end condition.
7. Vertical Openings [Score: 0]:
   A 90-minute fire-rated self-closing door in a wood frame was found at the bottom of the basement stairs. Because of the wood frame, enclosure protection of less than 1 hour is provided.
8. Hazardous Areas [Score: 0]:
   Again, for purposes of this FSES, the basement level was treated as a single hazardous area consisting of multiple rooms. This level is sprinkler protected throughout as required by NFPA 101A(01), Sec. 4.6.8.2 and smoke-separated as required by NFPA 101(00), Sec. 19.3.2.1.
9. Smoke Control [Score: 0]:
   This score was assigned per Footnote c to this Table and the fact that residents are not allowed on this level.
10. Emergency Movement Routes [Score: -8]:
    This score was assigned for the following reasons:
    - There is only one way out of the basement, which does not meet the requirements of NFPA 101(00), Sec. 19.2.4.1.
    - The path of travel is up a stairway that is enclosed with construction having less than 1-hour fire resistance as described in Item 7, Vertical Openings, above.
    - The door to the exterior from the stair enclosure is only 30.5 inches in clear width.
    - Headroom at the bottom of the basement stairway was found to be only 63 inches instead of the 80 inches required by NFPA 101(00), Sec. 7.1.5.
11. Manual Fire Alarm [Score: +2]:
    There is a manual fire alarm pull station along the path of travel from the basement. The building's fire alarm system is monitored by Criticom.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in NFPA 101A(01), Sec. 4.6.13.4.3 and Footnote *g* to this Table. The zone is protected with quick-response sprinklers. There is a system-connected smoke detector near the building's fire alarm control panel and another in the 'hallway' leading to the boiler room.

7. Vertical Openings [Score: 0]:
   While the self-closing door opening from the kitchen into the west stairway was found to be a 90-minute fire-rated assembly (including a metal frame), the stair enclosure walls are constructed of plaster on wood lath/gypsum wallboard on wood studs, which likely does not provide the 1-hour fire resistance required by NFPA 101(00), Sec. 19.3.1.1.
8. Hazardous Areas [Score: 0]:
   Hazardous areas were found to be sprinkler protected as required by NFPA 101A(01), Sec. 4.6.8.2 and smoke-separated as required by NFPA 101(00), Sec. 19.3.2.1.
9. Smoke Control [Score: 0]:
   This score was assigned per Footnote c to this Table (fewer than 31 residents).
10. Emergency Movement Routes [Score: -8]:
    While there are two ways out of this level, access to the rear (west) exit passes through the kitchen, which does not meet the requirements of NFPA 101(00), Sec. 7.5.1.7. From the kitchen, occupants must pass through a door that opens into the west stairway enclosure from the Second Floor. The door to the exterior from this enclosure is only 30.5 inches in clear width. The following deficient conditions were also noted:
    - The corridor narrows to 33 inches clear width because of the desk serving as the nurse station,
    - Resident room doors were found to be only 29.5 inches in clear width and, therefore, could not be credited as an egress route [see NFPA 101A(01), Sec. 4.6.10.3.2].
11. Manual Fire Alarm [Score: +2]:
    There are manual fire alarm pull stations at the front and back doors. The fire alarm system is monitored by Criticom.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in NFPA 101A(01), Sec. 4.6.13.4.3 and Footnote *g* to this Table. The zone is protected with quick-response sprinklers. System-connected smoke detectors were found in the Day Room/Dining Room area and in the corridors leading to the main entrance and to the kitchen. This was scored as "Corridor Only" smoke detection. Battery-operated single station smoke detectors were found in the resident sleeping rooms.
13. Automatic Sprinklers [Score: +10]:
    The building is protected by a supervised, wet-pipe automatic fire sprinkler system consisting of quick-response sprinklers.

Zone 3 – Second Floor:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

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

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -7]:
   Because of exposed wood joists found in the basement ceiling, the building was assigned a Type V(000) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Interior finish was found to be plaster or gypsum wallboard or a combination thereof.
3. Interior Finish (Rooms) [Score: +3]:
   Interior finish was found to be plaster or gypsum wallboard or a combination thereof.
4. Corridor Partitions/Walls [Score: 0]:
   Corridor walls are constructed of ½-inch thick gypsum wallboard installed over plaster on wood lath on both sides of wood studs. Because it appears that the corridor walls do not extend to the underside of the roof above, they were graded as "< ½ hour" in accordance with NFPA 101A(01), Sec. 4.6.4.2.
5. Doors to Corridor [Score: +1]:
   Corridor doors were found to be of 1-3/4-inch solid wood construction. The door to the bathroom was found to be of hollow core wood construction, but pursuant to direction given in NFPA 101A(00), Sec. 4.6.5, this door was not considered in classifying doors to corridors, as no flammable or combustible materials were found in the room.
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. The building measures approximately 70 feet in length on this level and Parameter 10 was assigned a score of -8. Due to the lack of complying means of egress out of this level, a dead-end condition is created.
7. Vertical Openings [Score: 0]:
   Twenty-minute-rated self-closing doors in steel frames were found at the top of the east and west stairways. The vertical openings, therefore, provide protection of less than the 1-hour fire resistance required by NFPA 101(00), Sec. 19.3.1.1
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.
9. Smoke Control [Score: 0]:
   This score was assigned per Footnote c to this Table (fewer than 31 residents).
10. Emergency Movement Routes [Score: -8]:
    There are two ways out of this level. However, as indicated in Item 7, Vertical Openings, the stair enclosures serving this level currently provide protection of less than 1-hour fire resistance, which does not meet the requirements of NFPA 101(00), Sections 7.2.2.5.1 and 7.1.3.2. The following deficient conditions were also noted:
    - The door to the exterior from the rear (west) stair enclosure is only 30.5 inches in clear width.
    - The door at the top of the front (east) stair enclosure, which used to swing over the stairs, was found to have been changed to swing into the corridor, which does not meet the requirements of NFPA 101(00), Sec. 7.2.1.4.3, and
    - Resident room doors were found to measure between 29 and 30 inches in clear width and, therefore, could not be credited as an egress route [see NFPA 101A(01), Sec. 4.6.10.3.2].
11. Manual Fire Alarm [Score: +2]:
    One manual fire alarm pull station was found at the door to the west stair. This appears to meet the intent of Exception No. 1 to NFPA 101(00), Sec. 19.3.4.2. The fire alarm system is monitored by Criticom.

12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in NFPA 101A(01), Sec. 4.6.13.4.3 and Footnote *g* to this Table. The zone is protected with quick-response sprinklers. A system-connected smoke detector was found in the corridor. Battery-operated single station smoke detectors were found in the resident sleeping rooms.
13. Automatic Sprinklers [Score: +10]:
    The building is protected by a supervised, wet-pipe automatic fire sprinkler system consisting of quick-response sprinklers.

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

It must be noted that the scores and values assigned to the parameters in the tables on the FSES worksheets were based on conditions found between 0845 hours and 1110 hours on 02/19/15. Any changes in those conditions after that date could affect the scores and values, either positively or negatively. Again, based on this evaluation, Southside Care Center **has** achieved a passing score on the FSES. No other assessment of the level of safety in this facility is either intended or implied by *Fire Safety Resources, LLC.*

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

Form Approved
OMB Exempt

ZONE 1 OF 3 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
SOUTHSIDE CARE CENTER	01 - MAIN BUILDING

ZONE(S) EVALUATED: BASEMENT

PROVIDER/VENDOR NO.	DATE OF SURVEY
24E507	02/19/15

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

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

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

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X	[ ]	=	[ ]

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X	[1.6]	=	[1]

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

SURVEYOR SIGNATURE	TITLE	DATE
Robert W Whittle — FIRE SAFETY RESOURCES, LLC	PRESIDENT	02/20/15
FIRE AUTHORITY SIGNATURE	TITLE	DATE
Fire Safety Supervisor	State Fire Marshal	3-17-15

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

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

TABLE 4.

Safety Parameters	Safety Parameters Values						
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II		
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)[e]	
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies	
	In Zone	Outside Zone	In Zone	In Adjacent Zone		
	-11	-5	-6	-2	(0)	
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone			
	-5(0)[c]	0	3			
10. Emergency Movement Routes	<2 Routes	Multiple Routes				
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)	
	(-8)	-2	0	1	5	
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm			
			W/O F.D. Conn.	W/F.D. Conn		
	-4		1	(2)		
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone	
	0(3)[g]	2(3)[g]	3(3)[g]	4	5	
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building			
	0	8	(10)			

NOTE:

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

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

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

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

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

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

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

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

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

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

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

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

CONCLUSIONS

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

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

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

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

Form Approved
OMB Exempt

ZONE 2 OF 3 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
SOUTHSIDE CARE CENTER	01-MAIN BUILDING
ZONE(S) EVALUATED: FIRST FLOOR	
PROVIDER/VENDOR NO.: 24E507	DATE OF SURVEY: 02/19/15

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

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

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

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X		=	

TABLE 3B. (EXISTING BUILDINGS)

	F		R	
0.6 X	7.9	=	4.7	= 5

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

SURVEYOR SIGNATURE		TITLE	DATE
Robert J. Imhoff	FIRE SAFETY RESOURCES, LLC	PRESIDENT	02/20/15
FIRE AUTHORITY SIGNATURE		TITLE	DATE
	Fire Safety Supervisor	State Fire Marshal	3-17-15

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

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

TABLE 4.

Safety Parameters	Safety Parameters Values						
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II		
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433
First	(-2)	0	-2	0	0	2	2
Second	-7	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4

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

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

7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.		
			<1 hr	≥1 hr to <2 hr	≥2 hr
	-14	-10	(0)	2(0)[e]	3(0)[e]
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies
	In Zone	Outside Zone	In Zone	In Adjacent Zone	
	-11	-5	-6	-2	(0)
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone		
	-5(0)[c]	0	3		
10. Emergency Movement Routes	<2 Routes	Multiple Routes			
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)
	(-8)	-2	0	1	5
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm		
			W/O F.D. Conn.	W/F.D. Conn	
	-4		1	(2)	
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone
	0(3)[g]	2(3)[g]	3(3)[g]	4	5
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building		
	0	8	(10)		

NOTE:

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

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

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

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

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

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

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

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

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

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

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

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

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

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

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

CONCLUSIONS

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

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

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

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

Form Approved
OMB Exempt

ZONE 3 OF 3 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
SOUTHSIDE CARE CENTER	01-MAIN BUILDING
ZONE(S) EVALUATED: SECOND FLOOR	
PROVIDER/VENDOR NO.: 24E507	DATE OF SURVEY: 02/19/15

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

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

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

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X		=	

TABLE 3B. (EXISTING BUILDINGS)

	F		R	
0.6 X	6.9	=	4.1	= 5

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

SURVEYOR SIGNATURE: Robert S. Imhoff, Fire Safety Resources, LLC	TITLE: President	DATE: 02/20/15
FIRE AUTHORITY SIGNATURE: Fire Safety Supervisor	TITLE: State Fire Marshal	DATE: 3-17-15

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

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

TABLE 4.

Safety Parameters	Safety Parameters Values						
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II		
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433
First	-2	0	-2	0	0	2	2
Second	(-7)	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4

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

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

7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.		
			<1 hr	≥1 hr to <2 hr	≥2 hr
	-14	-10	(0)	2(0)[e]	3(0)[e]
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies
	In Zone	Outside Zone	In Zone	In Adjacent Zone	
	-11	-5	-6	-2	(0)
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone		
	-5(0)[c]	0	3		
10. Emergency Movement Routes	<2 Routes	Multiple Routes			
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)
	(-8)	-2	0	1	5
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm		
			W/O F.D. Conn.	W/F.D. Conn	
	-4		1	(2)	
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone
	0(3)[g]	2(3)[g]	3(3)[g]	4	5
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building		
	0	8	(10)		

NOTE:

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

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

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

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

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

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

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

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

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

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

A. Using the classification of the building (i.e., New or Existing) and the floor where the zone is located circle the appropriate value in each of the three columns in Table 6.
B. Transfer the three circled values from Table 6 to the blocks marked S_a, S_b, and S_c in Table 7.
C. For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

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

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

CONCLUSIONS

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