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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: K4ZT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00780

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

2. STATE VENDOR OR MEDICAID NO. (L 2) **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 **7/24/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (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):

17. SURVEYOR SIGNATURE: Amy Charais, HFE NE II — Date: 09/8/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL: Kamala Fiske-Downing, Enforcement Specialist — Date: 9/8/2017 (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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 24E507
September 12, 2017

Ms. Catherine Scoville, Administrator
Southside Care Center
2644 Aldrich Avenue South
Minneapolis, MN 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 July 23, 2017 the above facility is certified for:

- 17 Skilled Nursing Facility/Nursing Facility Beds

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

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered
September 12, 2017

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

RE: Project Number SE507026

Dear Ms. Scoville:

On June 14 and July 24, 2017, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective June 19, 2017. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 26, 2017. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on May 26, 2017, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on July 14, 2017. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On August 25, 2017, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on July 14, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 23, 2017. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on August 25, 2017. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 23, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined our letter of July 24, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 26, 2017 be rescinded effective July 23, 2017. (42 CFR 488.417 (b))

- Per instance civil money penalty for the deficiencies cited at F223 and F226 will remain in effect. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective July 23, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective July 23, 2017, is to be rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

As we notified you in our letter of June 14, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 26, 2017.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: K4ZT

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3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
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2 AOA 3 Other

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FISCAL YEAR ENDING DATE: (L35) **06/30**

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

* Code: **B*** (L12)

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

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17. SURVEYOR SIGNATURE Date : Amy Charais, HFE NE II 08/21/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: Kamala Fiske-Downing, Enforcement Specialist 9/7/2017 (L20)

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04-Other Reason for Withdrawal
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05-Fail to Meet Health/Safety
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OTHER
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30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

July 24, 2017

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

RE: Project Number SE507026

Dear Ms. Scoville:

On June 14, 2017, we informed you that the following enforcement remedy was being imposed:

- **State Monitoring effective June 19, 2017. (42 CFR 488.422)**

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- **Civil money penalty for the deficiency cited at F223 and F226. (42 CFR 488.430 through 488.444)**

This was based on the deficiencies cited by this Department for an extended survey completed on May 26, 2017. The most serious deficiencies were found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On July 14, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the extended survey, completed on May 26, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 3, 2017. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our extended survey, completed on May 26, 2017. The deficiencies not corrected are as follows:

F0315 -- S/S: D -- 483.25(e)(1)-(3) -- No Catheter, Prevent UTI, Restore Bladder
F0492 -- S/S: D -- 483.70(b)(c) -- Comply With Federal/state/local Laws/prof Std

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

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions:

- **Civil money penalty for the deficiencies cited at K918 and F314, be imposed. (42 CFR 488.430 through 488.444)**

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

• Mandatory denial of payment for new Medicare and Medicaid admissions effective August 26, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective August 8, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 26, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

As we notified you in our letter of June 14, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 26, 2017.

The CMS Region V Office will notify you of their determination regarding the imposed and recommended remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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 electronic plan of correction should be directed to:

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506

Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 26, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	R 07/14/2017

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 An onsite post certification revisit (PCR) was completed on 7/14/17 to determine status of deficiencies issued as a result of the survey exited on 5/26/17. The certification tags that were corrected can be found on the CMS2567B. Also there are tag/s that were not found corrected at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 315} SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the	{F 315}		7/20/17

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

Electronically Signed | 08/01/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHSIDE CARE CENTER	2644 ALDRICH AVENUE SOUTH MINNEAPOLIS, MN 55408

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{F 315}	Continued From page 1 resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess for and develop appropriate interventions to improve continence for 2 of 4 residents (R11, R12) reviewed for urinary incontinence. Findings include: R11's quarterly Minimum Data Set (MDS) dated 3/2/17, indicated she was moderately cognitively impaired, frequently incontinent of bladder and independent with all activities of daily living. R11's care plan dated 7/11/17, identified urge, stress and functional incontinence. The care plan directed night staff to assist her to the bathroom every four hours or as needed or check and	{F 315}	R11's Qtly MDS dated 3/2/17 indicates she is moderately cognitively impaired, frequently Incontinent of bladder and Stand by assistance and/or Independent with all daily living activities. Housekeeping told surveyor he changed R11's sheets every day because they were urine soaked. R12's Qtly MDS dated 4/17/17 Indicates she is moderately cognitively impaired, frequently Incontinent of bladder and no Toileting program. On 7/1/17, Southside developed a Bowel and Bladder Policy. On 7/19/17, both	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 315}	Continued From page 2 change her if she refuses to get up. The care plan further indicated R11 used the bathroom independently with supervision. Other than checking the resident every two hours for incontinence, there was no assessment or plan developed to help improve the resident's level of continence. During and observation on 7/14/17, at 9:51 a.m., R11's room was observed to have a strong urine odor. At 12:14 p.m., R11 was putting clean sheets on her bed. During an interview on 7/14/17, at 1:24 p.m., housekeeper (HK)-A stated he was washing R11's linens every day because they were soaked with urine. R12's quarterly MDS dated 4/18/17, indicated she was moderately cognitively impaired, independent with toileting and personal hygiene, and was frequently incontinent of bladder with no toileting program. R12's care plan dated 5/18/17, identified functional bladder incontinence and indicated an inability to control her bladder related to age and cognitive deficits. The care plan directed staff to assist R12 to the bathroom every four hours at night or check and changer her is she refused. Other than assisting R12 to the toilet, there was no assessment or plan developed to help improve her level of continence. During and observation on 7/14/17, at 9:51 a.m., R12's room was observed to have a strong urine odor. During an interview on 7/14/17, at 1:24 p.m. HK-A stated he washes R12's bedding every day	{F 315}	residents completed a 3 day bladder assessment and their care plans were updated. Both residents will be toileted and/or checked and changed using incontinent pad to keep residents dry and clean to prevent skin breakdown. The facility will ensure all residents admitted to Southside will be assessed for Incontinence. Incontinent residents will receive assistance and/or supervision from staff. All residents will be assessed quarterly, through MDS assessment, for incontinence. If a resident is found to have incontinent episodes, a 3 day assessment will be completed and the care plan updated, Using the bowel and bladder assessment. Licensed and/or certified staff provides assistance with Incontinence. Incontinent residents will be checked, toileted and/or offered assistance. DON/designee to monitor incontinent residents quarterly and results will be reported at quarterly QA meetings. Administrator to discuss results with DON. Date of completion 7/20/17.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	R 07/14/2017

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 315}	Continued From page 3 because it was soaked with urine. During an interview on 7/14/17, at 12:16 p.m. the director of nursing (DON) stated no re-assessment of R11 and R12's bladder incontinence had been completed. She stated she care planned both residents to be assisted every four hours and stated it was to let them sleep. She stated "I don't know if it is working." She stated HK-A washed both R 11 and 12's linens that morning because they smelled of urine. A facility policy related to bladder assessment and incontinence was requested but not received.	{F 315}		
{F 492} SS=D	483.70(b)(c) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD (b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. (c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of	{F 492}		8/7/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	R 07/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 492}	Continued From page 4 age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to be in compliance with state licensure rules for administration of medications by unlicensed personnel, for 2 of 2 trained medication assistants (TMA-A, TMA-B). This had the potential to affect all 14 residents residing in the facility. Finding include: A post certification survey was conducted in the facility on 7/14/17. During the survey two TMA's were identified by the facility as responsible to administer resident medications. A request was made for training records/and or certificates to ensure completion of a TMA course or competency training. During an interview on 7/14/17, at 1:55 p.m., the director of nursing (DON) stated the TMA's were trained upon hire and indicated the training was hands on and lasted "about an hour." She stated she then gave them a packet to take home and asked them some questions. The DON stated there was no documentation of the training provided and documentation of the questions asked. She stated the pharmacy used to come to the facility to provide training but have not done it	{F 492}	Upon survey, 2 TMAs educational backgrounds were reviewed and found to be expired. TMAs #1 medication certificate was current but her NAR was not current. She will be testing out through the state with her skilled and written tests or Cna but continues to work on the floor as she has TMA certification. TMA #2 was trained by the DON through a formal training program with a test after completion. TMA #2 passed the test but she does not have post-secondary training so as of 8/14/17, she was taken off the schedule and will undergo formal training from a post-secondary training program. As of 8/14/17, only TMAs who have graduated from a Minnesota postsecondary educational institution and are current will be hired and work at Southside care center. TMAs are required to have a Postsecondary certification to work as a TMA. Southside Care Center will keep written	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 492}	Continued From page 5 in a while. The DON stated a training was schedule for August 2017 to be completed by the pharmacy. A facility policy titled Southside Care Center Trained Medication Assistant Policy, dated 1/20/16, indicated TMA's are utilized at the care center to pass medication. The policy further indicated TMA's must have a current Certified Nursing Assistant certificate and must be certified through a formal training program.	{F 492}	documentation verifying completion of the course. TMAs skills will be evaluated every 6 months. Date of completion is 8/14/17. The RN/designee will check all CNAs and TMAs upon hire and annually. Results will be discussed at QA. RN to monitor.	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: K4ZT

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 **05/26/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **17** (L18)
13.Total Certified Beds **17** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (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):

17. SURVEYOR SIGNATURE Date :
Amy Charais, HFE NE II 06/27/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/24/2017 (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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: K4ZT

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2 AOA 3 Other

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02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
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FISCAL YEAR ENDING DATE: (L35)
06/30

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From (a):
To (b):

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___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
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1861 (e) (1) or 1861 (j) (1): (L15)

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18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist — 07/24/2017 (L20)

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23. LTC AGREEMENT BEGINNING DATE
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(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
7/25/2017 (L33)

DETERMINATION APPROVAL

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

020499

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically Submitted
June 14, 2017

Mr. Stephen Musser, Administrator
Southside Care Center
2644 Aldrich Avenue South
Minneapolis, MN 55408

RE: Project Number SE507026, HE507016

Dear Mr. Musser:

On May 26, 2017, an extended survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered. In addition, at the time of the May 26, 2017 extended survey the Minnesota Department of Health completed an investigation of complaint number HE507016 that was found to be unsubstantiated.

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

> Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;
>
> No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);
>
> Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to

resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

Potential Consequences - the consequences of not attaining substantial compliance 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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on May 26, 2017, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

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:

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731 Fax: (507) 206-2711

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective June 19, 2017. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F223 and F226. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Southside Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 26, 2017. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to

conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 August 26, 2017 (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 November 26, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Please contact me if you have questions related to this eNotice.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	05/26/2017

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 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A survey was conducted by the Minnesota Department of Health on May 23, 24, 25, & 26, 2017. The survey resulted in an Immediate Jeopardy (IJ) at F223 related to the facility's failed response to to identify, report and thoroughly investigate, allegations of resident to resident abuse which resulted in a high potential for harm or death. The IJ which began on 5/24/17, was brought to the attention of the facility's executive director on 5/25/17, at 2:26 p.m. and was removed on 5/26/17, at 2:23 p.m. At the time of the survey, a complaint investigation were also completed at the time of the survey: An investigation of complaint HE507016 was completed. The complaint was not substantiated. In addition, an extended survey was conducted by the Minnesota Department of Health on 5/25/17 through 5/26/17.	F 000		
F 159 SS=D	483.10(f)(10)(i)-(iv) FACILITY MANAGEMENT OF PERSONAL FUNDS	F 159		7/3/17

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

Electronically Signed | 06/26/2017

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 159	Continued From page 1 (f)(10)(i) …If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (f)(10)(ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. (f)(10)(iii) Accounting and records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally	F 159		

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F 159	Continued From page 2 accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. (f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide free access to personal financial accounts for 3 of 3 residents (R15, R9, R10) reviewed for personal funds. Findings include: R15's Minimum Data Set (MDS) dated 3/14/17, indicated she was cognitively intact and independent with all activities of daily living (ADL's).	F 159	K0159 - Southside Care Center continues to make resident funds available on an ongoing basis seven days a week. During the week either the Director of Nursing or Administrator is available to provide resident funds. Both the DON and/or Administrator are available on weekends should a resident require access to their funds. There has never been a complaint made to the Management of Southside by residents that they did not have access to their	

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F 159	Continued From page 3 During interview on 5/23/17 at 1:40 p.m., R15 stated she was unable to access her personal funds on the weekends. R15 stated she was only able to get money from her account on Tuesdays and Thursdays when the administrator was in the facility. R9's quarterly MDS dated 3/14/17, indicated she was cognitively intact and independent with all ADL's. During interview on 5/23/17, at 2:00 p.m., R9 stated she could not access her funds on Sundays. R10's quarterly MDS dated 2/22/17, indicated she was cognitively intact and independent with ADL's. During an interview on 5/23/17 at 1:47 p.m., R10 stated she could only access her funds on Tuesdays and Thursdays, and was unable to access her personal funds on the weekends. During interview on 5/24/17, at 10:41 a.m., the administrator stated residents have access to their funds everyday, except for Saturdays and Sundays. The administrator stated when he is at he facility, residents can access their funds and stated the director of nursing (DON) also had access to the residents' personal funds. The administrator stated if "someone really needs something" on the weekend, either he or the DON would come to the facility to access the funds.	F 159	funds at any time. In an effort to ensure that this practice continues, there will be an RN on duty seven days/week on day shifts. The RN will have access to the resident funds. Residents will be advised that they have access 7 days/week and Southside will post a notice on the resident bulletin board to that effect. This additional action will allow residents to have access to their funds seven days/week without delay. This practice will go into effect beginning Monday, July 3,2017. The Administrator will ensure that resident funds are available seven days per week. The Administrator will randomly ask residents monthly whether they were able to access their funds for 3 months and then quarterly thereafter.	
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS	F 164		6/27/17

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F 164	Continued From page 4 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners,	F 164		

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F 164	Continued From page 5 medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide a private meeting place for residents and visitors for 2 of 3 residents (R2, R16) reviewed for privacy. Findings include: R2's admission Minimum Data Set (MDS), dated 5/7/17, indicated she had intact cognition and was independent with activities of daily living (ADL). R2's care plan dated 5/1/17, indicated she had no communication problems. During an observation on 5/24/17, on 5/24/17, at 7:40 a.m., R2's room was observed. R2 shared the room with three other people, her bed was located in the far right corner of the room and divided with a privacy curtain. During an interview on 5/24/17, at 7:41 a.m., R2 stated that she was meeting her psychiatrist at 2:00 p.m. that day and stated they would have to meet outside on the deck unless her roommates were out of the room. When asked if there was another place she could meet her psychiatrist, R2 shook her head no. On 5/25/17, at 11:45 a.m., the director of nursing (DON) stated there were no private rooms in the facility. The DON stated if a resident had a visitor such as a guardian or case worker, they could use the basement for meetings. During a follow up interview with R2 on 5/26/17,	F 164	K0164 - Southside has limited space for private meetings with family, health care personnel or others. It has been a practice for the lower level space occupied by the Administrator be made available. As a general rule, residents are not allowed in the lower level but an exception has been and will continue to be made to allow for private meetings and consultations. Southside will post a notice on the resident bulletin board informing residents that the lower level space will be made available for private meetings. Southside will also include a notice in the visitors sign-in book letting visitors know that they can request private space. Southside will also include a notice in resident's admission information so that they know that space can be made available for private meetings. The Administrator will monitor this practice to ensure that resident privacy can be accommodated. The Administrator will randomly ask residents whether they were able to have a private area to meet with family or other guests on a monthly basis for 3 months and then quarterly thereafter.	

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F 164	Continued From page 6	F 164		

at 8:37 a.m., she indicated she had not been told the basement was available for meeting privately with her psychiatrist. When asked what she usually does when having private conversations she stated, "I just sit on the steps or in the backyard if it's private."

R16's quarterly MDS dated 5/4/17, indicated she had intact cognition and was independent with all ADL's.

During an interview on 5/23/17 at 1:26 p.m., R16 stated she does not have a place to meet privately with a visitor.

During an interview on 5/24/17, at 9:22 a.m., R16 was meeting with a guest in the dining room of the facility. Two other residents were seated in the dining room. R16 stated her and the visitor were not talking about anything that required privacy at the time and stated she could go to her room if it was noisy in the dining room, but stated "I don't have any more privacy there." R16 stated when it's noisy or if multiple residents were in the dining room she did not think it was okay to meet in the dining room.

During an interview on 5/26/17,at 7:37 a.m., the DON said that it was okay for residents to meet in the basement of the facility if the resident was meeting with a family member or guardian.

During a subsequent interview on 5/26/17, 8:48 a.m., R16 stated that she had been told by staff she could meet with visitors in the dining room, in her room or outside. She stated he had not been told she could meet with a visitor in the basement and stated, "That area if off limits to us patients."

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F 164	Continued From page 7 A facility policy dated 11/09/15 indicated visitors were permitted from 8:00 AM to 8:00 PM. Visitors must sign in. During 5:00 PM to 8:00 PM, visitors restricted to first floor. No resident is allowed in another residents room 9:00 PM from 8:30 AM.	F 164		
F 167 SS=D	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by:	F 167		6/15/17

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F 167	Continued From page 8 Based on interview and document review, the facility failed to ensure survey results for the past three surveys were readily available for residents, visitors and staff to review upon request. This had the potential to affect all 15 residents, visitors and staff who wished to review this information. Findings include: During an initial tour conducted on 5/23/17, at 11:44 a.m., a black binder was noted to be available at a wall mount labeled "MDH Annual Survey." The black binder included the survey results and plan of correction from the 2016 health survey dated 4/21/16, and life safety survey dated 5/2/16. However, there were no additional surveys identified in the binder, nor was there a sign to indicate the preceeding three years worth of surveys were available upon request. During an interview on 5/24/17, at 10:38 a.m., the administrator stated he was not aware of the revised requirement for survey posting.	F 167	K0167 - On Thursday, June 15, 2017, a notice has been inserted into Southside's survey book indicating that the previous 2 State Survey are available upon request. The Administrator will ensure that the State Survey book is maintained and that three years of survey data is available. The Administrator will review the facility's survey book quarterly to ensure that (1) the notice that the previous 2 years are available upon request and that (2) the most recent survey result are maintained.	
F 223 SS=J	483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical	F 223		6/22/17

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F 223	Continued From page 9 abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to protect a resident from physical abuse. This resulted in an immediate jeopardy (IJ) for 1 of 1 resident (R3) who reported an allegation of abuse by a staff person, and other residents. The immediate jeopardy began on 5/23/17, when R3 made an allegation of abuse by a housekeeper and other residents in the facility. The IJ was identified on 5/25/17, and the administrator was notified of the IJ at 2:26 p.m. on 5/25/17. The IJ was removed on 5/26/17, but non-compliance remained at the lower scope and severity level of D. Findings include: R3's quarterly Minimum Data Set (MDS) dated 3/28/17, indicated she was cognitively intact and was independent with all activities of daily living. During an interview on 5/23/17, at 1:13 p.m., R3 stated housekeeper (HK)-A had raped her. R3 stated, "He's going to kill me." When asked, R3 stated she had not reported the incident to the facility staff. The incident was reported to the director of nursing (DON) on 5/23/17, at 1:24 p.m. by the surveyor. A review of a Southside Care Center Non-Fall Incident Report dated 5/23/17, indicated the following detailed description of the incident:	F 223	F223 - 1.Staff Education/Retraining □ Beginning on May 23rd, 2017: " All staff will be have completed Abuse Prevention Training. " For new employees as part of their orientation, o they will be required to acknowledge the receipt of the training materials, o complete the training, and " Certify completion. " The Director or Nursing or her designee will ensure that the training is completed for all employees. " With respect to this incident, all employees completed by May 30, 2017. 2. Resident Safety □ the immediate plan for R3 includes: " Nursing staff will check R3 every 30 minutes to ensure her safety. " R3 feels threatened by the housekeeper because of the tattoos on his arms. So in the future, when cleaning her personal area, R3 will be taken out of the area for cleaning. When possible and for the purposes of cleaning R3□s area, an alternate cleaner/bed maker will be identified to perform the cleaning or there will be two individuals present while the cleaning is completed.	

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F 223	Continued From page 10 'Resident (R3) has been taken off the Lithium due to medication side effects. Resident reported that she was raped. No witness.' The investigation indicated: 'Interviewed the accused person and he denied. Resident refusing to talk or to be interviewed.' There was no evidence of further investigation or interviews with staff or other residents. A review of a 5/23/17 untitled Document (identified as night shift charting), by LPN-A indicated R3 "is so delusional I cannot see why anyone believes what she says." As a result of the resident's allegations, additional incident reports were reviewed: A review of a Southside Care Center Fall/Presumed Fall Incident report dated 7/8/16, identified the following: Staff heard residents in room by nursing desk arguing then saw R3 get hit in the face and neck twice by her roommate (R9). The incident report indicated: "In this particular incident, this resident [R3] had been loud and agitating to other roommate earlier in the day." A Southside Care Center Non- Fall Incident Report dated 9/8/16, indicated staff was in the dining room passing medications and heard residents in room 102 yelling at each other. The report indicated R3's roommate had gone toward R3 and they began to fight. A correlating Southside Care Center progress note dated 9/8/16, indicated at about 7:30 p.m., staff heard yelling coming from R3's room. R9 was swearing at R3 and hitting her. The note indicated the DON had been notified.	F 223	" On Friday, May 26th, 2017, R3 has been sent to her physician for evaluation of her physical and mental state. " Should R3 experience an escalation in her behaviors that would create a threat to others, R3 will be referred to the Crisis Center for evaluation. " Should other residents create a threat to R3, they will be removed from R3 presence and evaluated for the appropriate intervention. " Any alleged or witness abuse involving R3 will be documented in an incident report. The Administrator and Director of Nursing (Program Manager) will be notified immediately for necessary reporting to the Common Entry Point. R3□s Guardian will be notified as well as the facility owners. " Facility staff will evaluate whether Southside can continue to provide a safe environment for R3. 3. Incident Report Documentation/Process - Allegation of Rape " An incident report was initiated on May 23rd, 2017 as the result of an interview with a State Surveyor where R3 reported that she was raped by the Housekeeper. R3 was then interviewed by the Director of Nursing where R3 denied that she was raped but was	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223	Continued From page 11 A Southside Care Center progress note dated 3/12/17, indicated: Incident between R4 and R3. R3 was making rude comments to R4. After R4 told R3 to shut up several times, R4 "jumped up and began hitting R3." There was no evidence the facility had investigated the incident any further. A review of an untitled document dated 4/19/17, indicated R9 "smacked R3 across the face." There was no indication an investigation had ensued. During a follow up interview with the DON on 5/24/17, at 9:45 a.m., the DON stated the alleged rape incident had not been reported to the State agency. The DON stated she had investigated the incident and stated the administrator would report it. Further, the DON stated the facility had 48 hours to file a report. During an interview on 5/24/17, at 10:17 a.m., the adminstrator stated he was made aware of the allegation the previous day. He stated he asked the DON to interview the people involved and document, and he would come to the facility in the morning and do additional interviews and report as necessary. The administrator stated he did not know if the allegation should be reported to the State agency. He said, "it depends on the resident, their history, and whether the allegation can be substantiated." He further stated he was not sure whether the investigation was complete, but verified HK-A continued to work during the investigation. During interview on 5/24/17 at 10:32 a.m., the DON stated the facility had not made a report to the State agency in over a year. She stated if a	F 223	frightened by the tattoos on the Housekeeper□s arm. " The facility understands that the allegation should have been reported within 2 hours and that was not done. The allegation was reported on Thursday, May 25th, 2017 to the Common Entry Point. A report will also be made to OHFC. " The facility will complete the investigation including the interview of other staff and residents. " A physical assessment is being completed for R3. " The Director of Nursing or her designee will continue to monitor R3□s behaviors and ensure that she is in a safe environment. She will be monitored by staff as noted above. 4. Incident Report documentation/Process □ Reports of R3 being hit/scratched by other resident. The incident report on file is over a year old and it was and still is unclear whether this was the incident, due to the age, that the facility needed to report. In the future, the facility understands that an incident report should be prepared with respect any physical altercation between residents and/or staff. The incident will be reported to the Common Entry Point and OHFC. The Director of Nursing or her designee will do an assessment of the residents involved to ensure that any care that is needed is provided. The Director of Nursing or her designee will do an	

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F 223	Continued From page 12 resident is hitting another resident, "We should report that." During interview with the administrator on 5/24/17, at 10:36 a.m., the administrator stated he was not made aware of the incidents involving resident to resident abuse. He stated he was not sure why these had not been reported. During observations on 5/24/17, at 12:52 p.m., R3 was in the dining room. She was observed to repeatedly request medication. Trained medication aide (TMA)-A stated to R3, "She's [the nurse] getting it for you, you speak English." At 12:59 p.m., R3 had not yet received her medication and requested it again. TMA-A asked R3 in a condescending tone, "Are you an RN (registered nurse)?, are you an LPN (licensed practical nurse)?, are you a doctor?" During an interview on 5/24/17, at 3:02 p.m., the DON stated R3 talks a lot and R4 is always asking her to stop. The DON stated R3 and R4 yell at each other every day. In addition, the DON stated if it happens during the day, staff intervene, but if it happens at night, staff are supposed to report to her or the administrator. The DON stated R3 had been sent to "crisis" more than once for agitation. She stated usually R3 is loud and other residents react to that. However, the DON stated she had never seen R3 physically abusive to another resident. The DON verified R3 had been sent out of the facility, not the resident who was hitting her, because the other resident is "usually the quiet one." HK-A was observed to be working independently again on 5/25/17. At 7:20 a.m. on 5/25/17, HK-A was interviewed and stated he had received	F 223	assessment of the perpetrator to try to identify root causes that trigger behaviors and develop a plan to reduce the tensions between residents. Where there is documented abuse of a resident for any reason, the Director of Nursing will monitor the corrective action(s) on a weekly basis for one month and then monthly for 6 months to ensure that any correction action is sustained. For the records, in the case of R3, the allegation of abuse was not sustained. NOTE: Due to R3□s behaviors, R3 was sent to the Crisis Center and given a 30 day discharge notice. On June 22, 2017, the facility was notified that R3 has or is in the process of being transferred to a facility that has agreed to accept R3 for admission.	

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F 223	Continued From page 13	F 223		

training on abuse. He then stated, "whatever I see, I don't say anything, I like to keep my nose clean, don't stick my nose where I'm not supposed to." HK-A stated if he saw a staff or another resident physically abusing a resident, he didn't know what he would do.

During an interview on 5/25/17, at 9:22 a.m., trained medication aide (TMA)-A stated she had never seen R3 be aggressive with another resident. TMA-A stated she was aware R4 had hit R3 but had never witnessed it. TMA-A stated, "During the day they [R3 and R4] are pretty good, on the evening and night shifts they argue and swear at each other 3-4 times per shift."

During an observation on 5/25/17, at 9:50 a.m., R3 was heard requesting insulin. The director of nursing (DON) walked over to R3 and yelled at her saying, "you go to your room, you are disturbing everyone."

During on observation on 5/26/17, at 6:54 a.m., R3 remained in the room she shared with R4.

During an interview on 5/26/17, at 8:22 a.m., R3's guardian (G)-A stated someone at the facility had contacted her the previous day about R3. She stated they had discussed R3's behaviors but had not informed them of the rape allegation. G-A stated she did not hear from the facility very often and was not even sure who the current DON was. G-A stated the facility had updated her regarding a medication change several weeks ago, but stated she had not been informed of any issues of resident to resident abuse. G-A stated, "I don't feel her [R3] needs are being met at this time."

While multiple reports had been made regarding

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F 223	Continued From page 14	F 223		

R3 being physically abused by other residents in the facility, there was no evidence the facility had investigated the abuses, nor were these incidents reported to the State agency. Further, while many of the altercations occurred between R3 and her roommate, there was no evidence the facility implemented interventions to keep R3 safe from the physical abuse. R3 and R4 remained in the same room even though the facility had identified multiple verbal and physical altercations between the two.

A facility policy titled Southside Care Center Vulnerable Adult Abuse Prevention and Investigation, dated 2/16/15, indicated: At Southside Care Center we are committed to providing a safe, comfortable living environment for all of our residents. To ensure safety, we practice abuse prevention and intervention. The policy directed staff to complete the following procedures after an incident: Administrator of designee will report event to the State agency. Complete an incident report. Update care plan and document in progress notes. Complete Investigation, including but not limited to interview of residents and staff.

The immediate jeopardy that began on 5/23/17, was removed on 5/26/17 at 2:23 p.m., when the facility had educated staff related to Abuse Prevention responsibilities/techniques, had implemented measures to provide for R3's safety including: 30 minute checks for increased supervision of R3, scheduled a medical assessment for R3 with her physician, and had modified staff assignments to promote R3's sense of safety and well being. In addition, the facility had initiated reports to the State agency, and had initiated investigations into the abuses

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F 223	Continued From page 15 R3 allegedly endured.	F 223		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities 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. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours	F 225		6/22/17

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F 225	Continued From page 16 after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 immediately report, and thoroughly investigate allegations of abuse to the administrator and State agency (SA) for 1 of 1 resident (R3) who alleged a staff member had sexually assaulted her, and alleged she'd been the victim of resident to resident abuse. In addition the facility failed to provide staff training related to abuse for 5 of 5 employees (Cook [C]-A, Trained medication aide [TMA]-B, TMA-A, registered nurse [RN]-A and housekeeper [HK]-A)	F 225	F225 - 1.Staff Education/Retraining □ Beginning on May 23rd, 2017: " All staff will be have completed Abuse Prevention Training. " For new employees as part of their orientation, o they will be required to acknowledge the receipt of the training materials, o complete the training, and " Certify completion.	

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F 225	Continued From page 17 reviewed for training. Findings include: R3's quarterly Minimum Data Set (MDS) dated 3/28/17, indicated she was cognitively intact and was independent with all activities of daily living. During an interview on 5/23/17, at 1:13 p.m., R3 stated housekeeper (HK)-A had raped her and R3 further stated, "He's going to kill me." R3 stated she had not reported the incident to the facility staff. This allegation of sexual abuse was immediately reported to the director of nursing (DON) following the interview with R3 on 5/23/17, at 1:24 p.m. by the surveyor. During a follow-up interview with the DON regarding the reporting, investigation and protection of R3 on 2/24/17, at 9:45 a.m., The DON stated the incident had not been reported to the State agency. The DON stated she had investigated the incident by talking to R3 and HK-A only and stated the administrator would report the incident. Further, the DON stated the facility had 48 hours to file a maltreatment report. A review of a Southside Care Center Non-Fall Incident Report dated 5/23/17, indicated the following detailed description of the incident: Resident (R3) has been taken off the Lithium due to medication side effects. Resident reported that she was raped. No witness. The investigation indicated: Interviewed the accused person and he denied. Resident refusing to talk or to be interviewed. There was no evidence of further investigation or interviews with staff or other	F 225	" The Director or Nursing or her designee will ensure that the training is completed for all employees. " With respect to this incident, all employees completed by May 30, 2017. 2. Resident Safety □ the immediate plan for R3 includes: " Nursing staff will check R3 every 30 minutes to ensure her safety. " R3 feels threatened by the housekeeper because of the tattoos on his arms. So in the future, when cleaning her personal area, R3 will be taken out of the area for cleaning. When possible and for the purposes of cleaning R3□s area, an alternate cleaner/bed maker will be identified to perform the cleaning or there will be two individuals present while the cleaning is completed. " On Friday, May 26th, 2017, R3 has been sent to her physician for evaluation of her physical and mental state. " Should R3 experience an escalation in her behaviors that would create a threat to others, R3 will be referred to the Crisis Center for evaluation. " Should other residents create a threat to R3, they will be removed from R3 presence and evaluated for the appropriate intervention. " Any alleged or witness abuse involving R3 will be documented in an incident report. The Administrator and	

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F 225	Continued From page 18 residents had been attempted/completed. During an interview on 5/24/17, at 10:17 a.m., the administrator stated he was made aware of R3's rape allegation reported to the DON the previous day. He stated he asked the DON to interview the people involved and document, and he would come in the morning and do additional interviews and report as necessary. The administrator stated he did not know if the allegation should be reported to the state agency. He stated it depends on the resident and their history and whether the allegation can be substantiated. A review of Southside Care Center Fall/Presumed Fall Incident report dated 7/8/16, identified the following: Staff heard residents in room by nursing desk arguing then saw R3 get hit in the face and neck twice by her room mate (R9). The incident report indicated: "In this particular incident, this resident [R3] had been loud and agitating to other room mate earlier in the day." There was no evidence of an investigation, nor was the incident reported to the state agency. A Southside Care Center Non- Fall Incident Report dated 9/8/16, indicated staff was in the dining room passing medications and heard residents in room 102 yelling at each other. R3's room mate went toward R3 and they began to fight. A correlating Southside Care Center progress note dated 9/8/17, indicated at about 7:30 p.m., staff heard yelling coming from R3's room. On investigating the yelling R9 was swearing at R3 and hitting her. The note indicated the DON was notified. A Southside Care Center progress note dated 3/12/17, indicated: Incident between R4 and R3.	F 225	Director of Nursing (Program Manager) will be notified immediately for necessary reporting to the Common Entry Point. R3□s Guardian will be notified as well as the facility owners. " Facility staff will evaluate whether Southside can continue to provide a safe environment for R3. 3. Incident Report Documentation/Process - Allegation of Rape " An incident report was initiated on May 23rd, 2017 as the result of an interview with a State Surveyor where R3 reported that she was raped by the Housekeeper. R3 was then interviewed by the Director of Nursing where R3 denied that she was raped but was frightened by the tattoos on the Housekeeper□s arm. " The facility understands that the allegation should have been reported within 2 hours and that was not done. The allegation was reported on Thursday, May 25th, 2017 to the Common Entry Point. A report will also be made to OHFC. " The facility will complete the investigation including the interview of other staff and residents. " A physical assessment is being completed for R3. " The Director of Nursing or her	

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F 225	Continued From page 19 R3 was making rude comments to R4. After R4 told R3 to shut up several times, R4 "jumped up and began hitting R3." There was no evidence the facility investigated the incident nor had it been reported to the state agency. A review of an untitled, document dated 4/19/17, indicated R9 "smacked R3 across the face." There was no indication of an investigation having been completed nor had this resident to resident altercation having been reported to the state agency. Nor was there any information that R3 was protected from further physical abuse from R9. During an interview on 5/24/17, at 10:32 a.m. regarding any incidents in the past few months regarding resident to resident abuse, the DON stated the facility had not made a report to the State agency in over a year. She stated if a resident is hitting another resident, "We should report that." During interview with the administrator on 5/24/17, at 10:36 a.m., the administrator stated he was not made aware of any resident to resident abuse. On informing him of the altercations between R9, and R4 in the past months he said that these incidents should have been reported but had not. REQUIRED STAFF TRAINING REGARDING ABUSE/NEGLECT: A review of employment files revealed the following: Cook (C)-A was hired on 10/19/16. An Inservice/education sheet in his personnel file	F 225	designee will continue to monitor R3□s behaviors and ensure that she is in a safe environment. She will be monitored by staff as noted above. 4. Incident Report documentation/Process □ Reports of R3 being hit/scratched by other resident. The incident report on file is over a year old and it was and still is unclear whether this was the incident, due to the age, that the facility needed to report. In the future, the facility understands that an incident report should be prepared with respect any physical altercation between residents and/or staff. The incident will be reported to the Common Entry Point and OHFC. The Director of Nursing or her designee will do an assessment of the residents involved to ensure that any care that is needed is provided. The Director of Nursing or her designee will do an assessment of the perpetrator to try to identify root causes that trigger behaviors and develop a plan to reduce the tensions between residents. Where there is documented abuse of a resident for any reason, the Director of Nursing will monitor the corrective action(s) on a weekly basis for one month and then monthly for 6 months to ensure that any correction action is sustained. For the records, in the case of R3, the allegation of abuse was not sustained.	

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F 225	Continued From page 20 was blank. There was no evidence he had received training on abuse. Trained medication aide (TMA)-B was hired on 5/15/16. TMA-B's personnel file did not contain evidence of abuse training. TMA-A was hired 4/1/16. Her personnel file lacked evidence of abuse training. Registered nurse (RN)-A was hired on 5/11/17. Her personnel file lacked evidence of abuse training. Housekeeper (HK)-A was hired 11/30/16. His personnel file lacked evidence of abuse training. During an interview on 5/26/17 at 7:32 a.m., the DON stated staff training was done at almost every monthly staff meeting. The DON stated if a staff person missed a training, the staff person could complete that training utilizing the information on the topic that was available to staff in a binder at the facility. Staff would then sign on the appropriate training sheet. She stated she could not find the list of staff that had received abuse training and stated she provided training following the request for records by the surveyor. A facility policy titled Southside Care Center Vulnerable Adult Abuse Preventions and Investigation, dated 2/16/15, indicated the following: To ensure the safety of residents and visitors, we practice abuse prevention and intervention. the policy indicated the facility will report allegations of abuse to the state agency. The policy further indicated all employees will be informed of the abuse prevention plan upon orientation.	F 225	NOTE: Due to R3□s behaviors, R3 was sent to the Crisis Center and given a 30 day discharge notice. On June 22, 2017, the facility was notified that R3 has or is in the process of being transferred to a facility that has agreed to accept R3 for admission.	

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F 226 SS=F	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse prohibition policies and procedures related to immediate	F 226	F226 - 1.Staff Education/Retraining □ Beginning on May 23rd, 2017:	6/22/17

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F 226	Continued From page 22 reporting and thorough investigation of alleged abuse for 1 of 1 resident (R3); in addition, the facility failed to ensure all staff received training related to abuse, and procedures for reporting abuse, for 5 of 5 employees (Cook [C]-A, Trained medication aide [TMA]-B, TMA-A, registered nurse [RN]-A and housekeeper [HK]-A) whose personnel records were reviewed for training. Findings include: A facility policy titled Southside Care Center Vulnerable Adult Abuse Preventions and Investigation, dated 2/16/15, indicated the following: To ensure the safety of residents and visitors, we practice abuse prevention and intervention. the policy indicated the facility would report allegations of abuse to the State agency. The policy further directed staff to complete the following procedures after an incident: Administrator or designee will report event to the State agency. Complete an incident report. Update care plan and document in progress notes. Complete Investigation, including but not limited to interview of residents and staff. In addition, the policy indicated all employees would be informed of the facility's abuse prevention plan upon orientation. R3's quarterly Minimum Data Set (MDS) dated 3/28/17, indicated she was cognitively intact and was independent with all activities of daily living. During an interview on 5/23/17, at 1:13 p.m., R3 stated housekeeper (HK)-A had raped her. R3 also stated, "He's going to kill me." When asked, R3 stated she had not reported the incident to the facility staff.	F 226	" All staff will be have completed Abuse Prevention Training. " For new employees as part of their orientation, o they will be required to acknowledge the receipt of the training materials, o complete the training, and " Certify completion. " The Director or Nursing or her designee will ensure that the training is completed for all employees. " With respect to this incident, all employees completed by May 30, 2017. 2. Resident Safety the immediate plan for R3 includes: " Nursing staff will check R3 every 30 minutes to ensure her safety. " R3 feels threatened by the housekeeper because of the tattoos on his arms. So in the future, when cleaning her personal area, R3 will be taken out of the area for cleaning. When possible and for the purposes of cleaning R3s area, an alternate cleaner/bed maker will be identified to perform the cleaning or there will be two individuals present while the cleaning is completed. " On Friday, May 26th, 2017, R3 has been sent to her physician for evaluation of her physical and mental state. " Should R3 experience an escalation in her behaviors that would create a threat to others, R3 will be referred to the Crisis Center for evaluation.	

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F 226	Continued From page 23 The incident was reported to the director of nursing (DON) on 5/23/17, at 1:24 p.m. by the surveyor. A review of a Southside Care Center Non-Fall Incident Report dated 5/23/17, indicated the following detailed description of the incident: 'Resident (R3) has been taken off the Lithium due to medication side effects. Resident reported that she was raped. No witness.' The investigation indicated: 'Interviewed the accused person and he denied. Resident refusing to talk or to be interviewed.' There was no evidence of further investigation or interviews with staff or other residents. A review of a 5/23/17 untitled Document (identified as night shift charting), by LPN-A indicated R3 "is so delusional I cannot see why anyone believes what she says." As a result of the resident's allegations, additional incident reports were reviewed: A review of a Southside Care Center Fall/Presumed Fall Incident report dated 7/8/16, identified the following: Staff heard residents in room by nursing desk arguing then saw R3 get hit in the face and neck twice by her roommate (R9). The incident report indicated: "In this particular incident, this resident [R3] had been loud and agitating to other roommate earlier in the day." A Southside Care Center Non- Fall Incident Report dated 9/8/16, indicated staff was in the dining room passing medications and heard residents in room 102 yelling at each other. The report indicated R3's roommate had gone toward	F 226	" Should other residents create a threat to R3, they will be removed from R3 presence and evaluated for the appropriate intervention. " Any alleged or witness abuse involving R3 will be documented in an incident report. The Administrator and Director of Nursing (Program Manager) will be notified immediately for necessary reporting to the Common Entry Point. R3□s Guardian will be notified as well as the facility owners. " Facility staff will evaluate whether Southside can continue to provide a safe environment for R3. 3. Incident Report Documentation/Process - Allegation of Rape " An incident report was initiated on May 23rd, 2017 as the result of an interview with a State Surveyor where R3 reported that she was raped by the Housekeeper. R3 was then interviewed by the Director of Nursing where R3 denied that she was raped but was frightened by the tattoos on the Housekeeper□s arm. " The facility understands that the allegation should have been reported within 2 hours and that was not done. The allegation was reported on Thursday, May 25th, 2017 to the	

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F 226	Continued From page 24 R3 and they began to fight. A correlating Southside Care Center progress note dated 9/8/16, indicated at about 7:30 p.m., staff heard yelling coming from R3's room. R9 was swearing at R3 and hitting her. The note indicated the DON had been notified. A Southside Care Center progress note dated 3/12/17, indicated: Incident between R4 and R3. R3 was making rude comments to R4. After R4 told R3 to shut up several times, R4 "jumped up and began hitting R3." There was no evidence the facility had investigated the incident any further. A review of an untitled document dated 4/19/17, indicated R9 "smacked R3 across the face." There was no indication an investigation had ensued. During a follow up interview with the DON on 5/24/17, at 9:45 a.m., the DON stated the alleged rape incident had not been reported to the State agency. The DON stated she had investigated the incident and stated the administrator would report it. Further, the DON stated the facility had 48 hours to file a report. During an interview on 5/24/17, at 10:17 a.m., the administrator stated he was made aware of the allegation the previous day. He stated he asked the DON to interview the people involved and document, and he would come to the facility in the morning and do additional interviews and report as necessary. The administrator stated he did not know if the allegation should be reported to the State agency. He said, "it depends on the resident, their history, and whether the allegation can be substantiated." He further stated he was	F 226	Common Entry Point. A report will also be made to OHFC. " The facility will complete the investigation including the interview of other staff and residents. " A physical assessment is being completed for R3. " The Director of Nursing or her designee will continue to monitor R3□s behaviors and ensure that she is in a safe environment. She will be monitored by staff as noted above. 4. Incident Report documentation/Process □ Reports of R3 being hit/scratched by other resident. The incident report on file is over a year old and it was and still is unclear whether this was the incident, due to the age, that the facility needed to report. In the future, the facility understands that an incident report should be prepared with respect any physical altercation between residents and/or staff. The incident will be reported to the Common Entry Point and OHFC. The Director of Nursing or her designee will do an assessment of the residents involved to ensure that any care that is needed is provided. The Director of Nursing or her designee will do an assessment of the perpetrator to try to identify root causes that trigger behaviors and develop a plan to reduce the tensions between residents. Where there is documented abuse of a resident for any reason, the Director of	

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F 226	Continued From page 25 not sure whether the investigation was complete, but verified HK-A continued to work during the investigation. During interview on 5/24/17 at 10:32 a.m., the DON stated the facility had not made a report to the State agency in over a year. She stated if a resident is hitting another resident, "We should report that." During interview with the administrator on 5/24/17, at 10:36 a.m., the administrator stated he was not made aware of the incidents involving resident to resident abuse. He stated he was not sure why these had not been reported. HK-A was observed to be working independently again on 5/25/17. At 7:20 a.m. on 5/25/17, HK-A was interviewed and stated he had received training on abuse. He then stated, "whatever I see, I don't say anything, I like to keep my nose clean, don't stick my nose where I'm not supposed to." HK-A stated if he saw a staff or another resident physically abusing a resident, he didn't know what he would do. During an interview on 5/25/17, at 9:22 a.m., trained medication aide (TMA)-A stated she had never seen R3 be aggressive with another resident. TMA-A stated she was aware R4 had hit R3 but had never witnessed it. TMA-A stated, "During the day they [R3 and R4] are pretty good, on the evening and night shifts they argue and swear at each other 3-4 times per shift." While multiple reports had been made regarding R3 being physically abused by other residents in the facility, there was no evidence the facility had investigated the abuses, nor were these incidents	F 226	Nursing will monitor the corrective action(s) on a weekly basis for one month and then monthly for 6 months to ensure that any correction action is sustained. For the records, in the case of R3, the allegation of abuse was not sustained. NOTE: Due to R3□s behaviors, R3 was sent to the Crisis Center and given a 30 day discharge notice. On June 22, 2017, the facility was notified that R3 has or is in the process of being transferred to a facility that has agreed to accept R3 for admission.	

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F 226	Continued From page 26	F 226		

reported to the State agency. Further, while many of the altercations occurred between R3 and her roommate, there was no evidence the facility implemented interventions to keep R3 safe from the physical abuse. R3 and R4 remained in the same room even though the facility had identified multiple verbal and physical altercations between the two.

A review of employment files revealed the following:

Cook (C)-A was hired on 10/19/16. An Inservice/education sheet in his personnel file was blank. There was no evidence he had received training on abuse.

Trained medication aide (TMA)-B was hired on 5/15/16. TMA-B's personnel file did not contain evidence of abuse training.

TMA-A was hired 4/1/16. Her personnel record lacked evidence of abuse training.

Registered nurse (RN)-A was hired on 5/11/17. Her personnel file lacked evidence of abuse training.

Housekeeper (HK)-A was hired on 11/30/16. His personnel file lacked evidence of abuse training.

During an interview with the DON on 5/26/17 at 7:32 a.m., the DON stated staff training was done at almost every monthly staff meeting. The DON stated if a staff person missed training, that person could complete the training utilizing the information on the topic that was available to staff in a binder at the facility. The DON further stated staff were then expected to sign an appropriate

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F 226	Continued From page 27 training sheet. The DON confirmed she could not find the list of staff who had received abuse training, and stated she'd completed training for staff following the request for training records.	F 226		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions related to incontinence for 1 of 3 residents (R11) reviewed for urinary incontinence. Findings include: R11's quarterly Minimum Data Set (MDS) dated 3/2/17, indicated she was moderately cognitively impaired, frequently incontinent of bladder and independent with all activities of daily living. R11's care plan dated 5/18/17, identified urge, stress and functional incontinence. The care plan directed staff to encourage her to use the bathroom prior to going to bed and indicated she used the bathroom independently. The care plan further directed staff to prompt and check R11 at least every two hours for incontinence and to encourage her to wash, rinse and dry soiled areas on her body.	F 282	F282 - The following plan of correction applies to R12, and other residents who display a bowel or bladder problem. R11 and R12 have been incontinent of bladder. The care plan will reflect that facility staff will ensure both residents are assisted to the toilet at least every 4 hours and as needed during the night shift. They will be toileted or checked and changed using incontinent pad to keep residents dry and clean to prevent skin breakdown. The facility will ensure that night has qualified staff NAR/ TMA□s or LPN to perform patient cares. The facility will ensure any resident who is admitted to the facility will be assessed and evaluated for incontinence. Incontinent residents will receive assistance or supervision from qualify	6/30/17

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F 282	Continued From page 28 During observation on 5/25/17 at 8:24 a.m., R11's bed was noted to be stripped of linens. During an interview on 5/25/17 at 8:25 a.m., housekeeper (HK)-A stated he washed R12's bedding almost every day because it gets soaked with urine. During an observation on 5/26/17 at 9:04 a.m., trained medication aide (TMA)-A entered R11's room and asked R11 if she had been incontinent. R11 confirmed she had been incontinent. TMA-A brought a brief into the room and handed it to R11 and told her her she had 30 minutes to get out to breakfast. TMA-A did not encourage R11 to use the bathroom nor did she prompt her to wash herself. During interview on 5/26/17 at 9:11 a.m., R11 stated she is wet "just about every morning" and was wet during the night. She stated that she changes her brief herself, but doesn't' wash up and that no-one checks her skin. At that time, there was no washcloth, towel or wet wipes available in her room. R11 was observed sitting on the edge of her bed where she removed her soiled slacks and undergarment. When she removed the soiled brief she put it on the floor. R11 did not use the bathroom, and put a clean brief on without washing her perineal area to remove the urine. The resident was observed to do all this independenty with no staff in the area to cue or assist her. During an interview on 5/26/17 at 10:02 a.m., the director of nursing (DON) stated she was planning for R11 "to go" (leave the facility). The DON further stated their staff are not nursing	F 282	staff daily. Identified residents will be checked and toileted during night shift. Night staff including NAR/ TMA□s or LPN will assist with this duty. When the resident continues to decline the facility will give 30 day discharge notice. The facility does not keep any resident who is not able to care for himself or herself. The Director of Nursing will monitor this and ensure that the proper documentation is prepared and reflected in the MDS. In addition, the DON/ nurse manager will ensure TMA□s are trained on hired date and evaluated every 6 months to keep their skills. In addition, staff who are both Certified Nursing assistants and Trained Medication Aides will be employed as CNA/TMA's so that they can assist residents as needed. The DON will accomplish the following on the first of each month: 1. Endure that the in-service training schedule is maintained and that all employees affected have taken the required in-services. 2. Ensure that all required licenses are maintained by reviewing expiration dates so that all licenses are current. Staff who do not meet these standards will be warned and given the opportunity to rectify their shortcomings. If not, staff will be terminated. The Administrator will ensure that these practices are employed and meet with the	

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F 282	Continued From page 29 assistants and cannot take care of R11's needs.	F 282	DON monthly to assure compliance. Compliance with these standards will also be reviewed at the quarterly Quality Assurance meeting	
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the	F 315		6/30/17

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F 315	Continued From page 30 facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement interventions related to improve continence and personal hygiene to prevent infection, for 2 of 4 residents (R11, R12) reviewed for urinary incontinence. Findings include: R11's quarterly Minimum Data Set (MDS) dated 3/2/17, indicated she was moderately cognitively impaired, frequently incontinent of bladder and independent with all activities of daily living. R11's care plan dated 5/18/17, identified urge, stress and functional incontinence. The care plan directed staff to encourage her to use the bathroom prior to going to bed and indicated she used the bathroom independently. The care plan further directed staff to prompt and check R11 at least every two hours for incontinence and to encourage her to wash, rinse and dry soiled areas on her body. Other than checking the resident every two hours for incontinence, there was no assessment or plan developed to help improve the resident's level of continence. During observation on 5/25/17 at 8:24 a.m., R11's bed was noted to be stripped of linens. During an interview on 5/25/17 at 8:25 a.m., housekeeper (HK)-A stated he washed residents' bedding once per week. However stated he washes R12's bedding almost every day because	F 315	F315 - The following plan of correction applies to R12, and other residents who display a bowel or bladder problem. R11 and R12 have been incontinent of bladder. The care plan will reflect that facility staff will ensure both residents are assisted to the toilet at least every 4 hours and as needed during the night shift. They will be toileted or checked and changed using incontinent pad to keep residents dry and clean to prevent skin breakdown. The facility will ensure that night has qualified staff NAR/ TMA□s or LPN to perform patient cares. The facility will ensure any resident who is admitted to the facility will be assessed and evaluated for incontinence. Incontinent residents will receive assistance or supervision from qualify staff daily. Identified residents will be checked and toileted during night shift. Night staff including NAR/ TMA□s or LPN will assist with this duty. When the resident continues to decline the facility will give 30 day discharge notice. The facility does not keep any resident who is not able to care for himself or herself. The Director of Nursing will monitor this on an ongoing monthly basis and ensure that the proper documentation is prepared	

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F 315	Continued From page 31 it gets soaked with urine. During an observation on 5/26/17 at 9:04 a.m., trained medication aide (TMA)-A entered R11's room and asked R11 if she had been incontinent. R11 confirmed she had been incontinent. TMA-A brought a brief into the room and handed it to R11 and told her her she had 30 minutes to get out to breakfast. TMA-A did not encourage R11 to use the bathroom nor did she prompt her to wash herself. During interview on 5/26/17 at 9:11 a.m., R11 stated she is wet "just about every morning" and was wet during the night. She stated that she changes her brief herself, but doesn't' wash up and that no-one checks her skin. At that time, there was no washcloth, towel or wet wipes available in her room. R11 was observed sitting on the edge of her bed where she removed her soiled slacks and undergarment. When she removed the soiled brief she put it on the floor. She then put a clean brief on without washing her perineal area to remove the urine. The resident was observed to do all this independenty with no staff in the area to cue or assist her. During an interview on 5/26/17 at 10:02 a.m., the director of nursing (DON) stated she was planning for R11 "to go." The DON further stated their staff are not nursing assistants and cannot take care of R11's needs. R12's quarterly MDS dated 4/18/17, indicated she was moderately cognitively impaired, independent with toileting and personal hygiene, and was frequently incontinent of bladder with no toileting program. R12's care plan dated 5/18/17, identified functional bladder incontinence and	F 315	and reflected in the MDS. All findings will be reported at the quarterly Quality Assurance meeting. The Administrator will meet with the Director of Nursing monthly to monitor residents who are at risk and may need to be transferred to a higher level of care.	

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indicated an inability to control her bladder related to age and cognitive deficits. The care plan directed staff to assist R12 to the bathroom as needed. Other than assisting the resident "as needed", there was no assessment or plan developed to help improve the resident's level of continence.

An untitled document (identified as the overnight charting book) included an entry dated 4/25/17, which indicated R12 asked staff for a supply of depends. The entry note indicated staff had told R12 she'd already been provided depend during the evening shift and that she could not use them every hour. Another entry dated 5/6/17, included: [R12] "peed on the floor this morning. I made her clean it up."

During an observation on 5/25/17, at 8:24 a.m., R12's bed was observed to have been stripped of all bedding.

During an interview on 5/25/17 at 8:25 a.m., HK-A stated he washes R12's bedding almost every day because it was soaked with urine.

During an interview on 5/25/17 at 9:16 a.m., the director of nursing (DON) stated R12 was purposefully incontinent of bladder and stated if R12 felt any wetness, she would request an incontinent brief every hour. The DON verified R12 was identified in her care plan as "unable to control her bladder."

During an interview on 5/25/17, at 9:29 a.m.,TMA-A stated staff are always trying to keep up with R12's incontinence. She stated R12 required a lot of verbal cues, but stated staff did not physically assist R12 with any cares.

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	24E507	A. BUILDING _____ B. WING _____	05/26/2017

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 315	Continued From page 33 During observation on 5/26/17 at 6:50 a.m., R12 walked from her room into the bathroom next door. She came back out asking for an incontinent brief. At that time, her room had a strong urine odor near her bed. During an interview on 5/26/17 at 7:03 a.m., licensed practical nurse (LPN)-A stated she worked the overnight shift and was the only staff in the building overnight. LPN-A stated there was only one resident in the facility who was incontinent. She stated R12 was not incontinent and did not receive toileting assistance. A facility policy related to toileting and incontinence care was requested but not received.	F 315		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in	F 371		6/28/17

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F 371	Continued From page 34 accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to store and prepare food in a safe and sanitary manner to prevent the potential for food born illness. This had the potential to affect only a few residents who requested poached eggs for their meal. Findings include: During an initial kitchen tour on 5/23/17, at 12:40 p.m., the refrigerator was noted to have eggs in it. However, the eggs were not pasteurized even though they served them to residents poached. A Facility menu titled "Week at a Glance", dated May 2017 was noted to have poached eggs on the menu every other Sunday morning. During an interview on 5/23/17, at 12:40 p.m., cook (C)-A stated the facility does not use pasteurized eggs and stated poached eggs are served every other Sunday. During a subsequent interview on 5/24/17, at 12:37 p.m., CA-A stated the facility did not check the temperature of food prior to serving and not the poached eggs. He stated there were no logs for food temperatures and had not seen any since he started in October of 2016. During interview on 12/24/16, at 1:46 p.m., the	F 371	K371 - In consultation with the facility□s Dietician, the following steps are being taken to address this citation: 1. The facility□s menu selection will be modified to eliminate poached eggs or any egg recipe where the egg temperature does not reach 160 degrees. The facility will not be purchasing pasteurized eggs at this time. 2. On Wednesday, June 28th at 2:00pm, the Dietician will be conducting an in-service with the following topics: a. Kitchen cleaning schedule b. Monitoring food temperatures c. Labeling and dating food items 3. The Dietician will also be conducting sanitary audits monthly for 3 months and for 6 months thereafter. 4. Any additional food service support personnel will be provided necessary in-service including proper handwashing techniques. 5. The Administrator and Dietician will be responsible for following up ensuring that the kitchen cleaning, monitoring of food	

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F 371	Continued From page 35 registered dietician (RD) stated she performs an on site visit about 2 times per month. The RD stated she expected the cooks to be checking food temperatures prior to serving and documenting the temperatures on a log. She stated she had not audited for the use of temperature logs. The RD further stated she thought the facility was using pasteurized eggs because the poached eggs were served "runny." During an interview on 5/26/17, at 7:19 a.m., C-B stated he worked the weekends and stated he had been cooking the poached eggs on Sundays. C-B stated the yolks in the poached eggs were "hot", but "not solid." It was learned that there were no outbreaks of food bourne illness in the past six months. A facility policy titled, Southside Center Care Center Food Service - dated April 1, 2010, indicated "All state, federal and local standards and regulations are followed to ensure safe and sanitary kitchen and dining area."	F 371	temperature and labeling and dating food items is maintained.	
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 428		6/23/17

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F 428	Continued From page 36 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 428		

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F 428	Continued From page 37 Based on interview and document review, the facility failed to act on and implement pharmacist's recommendations for a gradual dose reductions (GDR)'s for 1 of 5 residents (R5) reviewed for unnecessary medications. Findings include: R5's annual Minimum Data Set (MDS) dated 4/27/17, indicated she was cognitively intact and independent with all activities of daily living. R5's care plan dated 5/21/17, identified a mood problem related to diagnosis of Schizophrenia and insomnia. A review of R5's Southside Care Center Physician's Orders, dated 5/5/17, indicated an order for Trazodone (Trazodone is an anti-depressant used to aide in sleep) HCL 50 milligrams by mouth nightly as needed for sleep. A review of an Omnicare Pharmacy review sheet indicated on 2/2017, the consultant pharmacist (CP) reviewed R5's medications, the report indicated, See pharmacy report for recommendations. The March 2017 review indicated Trazodone use nightly, no irregularities. The April review indicated Trazodone nightly, GDR pending. The May 2017 review indicated Trazodone nightly, director of nursing (DON) working on GDR. During an interview on 5/26/17, at 9:23 a.m., the DON stated when the pharmacy makes a recommendation, she gives it to her to put it in the chart. She stated she did not know where the recommendations for the Months of February through May 2017 were for R5.	F 428	K428 - We believe there was some confusion regarding the discussion of this citation and would like to clarify our practice. The Pharmacy Consultant prepares a monthly set of recommendations that are provided to the DON/ Nurse Manage. The DON and/or Nurse Manager will ensure that pharmacy recommendations will be followed closely, faxed to the primary physician or psychiatrist for concurrence and or modification of the recommendation. The DON/Nurse Manager will implement approved changes once received back from the primary physician or psychiatrist. The Pharmacy Consultant is relatively new for our facility and had started the practice of sending the recommendation to the administrator as well as the DON. The Administrator forwarded the recommendations to the Medical Director for review and signature. Since the Medical Director does not follow any of the residents at Southside, we are going to stop this practice since the recommendations are being sent the primary physician. Southside will continue to send pharmacy consultant recommendations and ensure that they are returned from the primary physician or psychiatrist and implemented. The DON will monitor this practice monthly and share any problems/issues at the quarterly Quality Assurance Committee for follow-up by the	

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F 428	Continued From page 38 During an interview on 5/26/17, at 9:30 a.m., the administrator stated he sent the pharmacy recommendations to the physicians and stated, "presumably" the physician mails them back. He stated if the DON does not get them back she would let him know. He stated, "I send them, I don't check to make sure they come back." During an interview on 5/26/17, at 9:23 a.m., the CP stated she made a recommendation to do a dose reduction on R5's Trazodone. She stated she continued to make the same recommendation for the next three months (March, April and May 2017). She stated she thought the DON was working on the GDR for R5. A facility policy was requested, but not received.	F 428	Medical Director and/or Administrator	
F 492 SS=F	483.70(b)(c) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD (b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. (c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of	F 492		6/30/17

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F 492	Continued From page 39 race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to be in compliance with state licensure rules for administration of medications by unlicesed personnel, for 2 of 2 trained medication assistants (TMA-A & TMA-B). This had the potential to affect all 15 residents residing in the facility. Finding include: An extended survey was conducted in the facility from 5/26/17 to 6/8/17. During the survey two TMA's were identified by the facility as responsible to administer resident medications. A request was made for training records/and or certificates to ensure completion of a TMA course or competency training, During an interview on 6/8/17, at 10:42 a.m., the director of nursing (DON) stated neither TMA-A or TMA-B had certificates of a completed TMA course and the DON stated the facility did not require such. The DON stated she trains the TMA's in the facility, and that there was no other formal training program, nor documentation of the	F 492	K492 - The DON/ nurse manager will ensure TMA□s are trained on hired date and evaluated every 6 months to keep their skills. In addition, staff who are both Certified Nursing assistants and Trained Medication Aides will be employed as CNA/TMA's so that they can assist residents as needed. The Administrator will ensure that these practices are employed and monitor it on a monthly basis.	

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F 492	Continued From page 40 training provided. A facility policy titled Southside Care Center Trained Medication Assistant Policy, dated 1/20/16, indicated TMA's are utilized at the care center to pass medication. The policy further indicated TMA's must have a current Certified Nursing Assistant certificate and must be certified through a formal training program.	F 492		
F 520 SS=F	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of	F 520		7/3/17

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F 520	Continued From page 41 action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the medical director was in regular attendance at least quarterly for the quality assurance (QA) meetings. This had the potential to affect all 15 residents residing in the facility. Findings include: A review of the facility's Southside Care Center Quality Assurance Meeting attendance sheets indicated the following: QA meeting dated 5/4/17 included attendance by the director of nursing (DON), pharmacy consultant, the activity director, housekeeper and medical director. QA meetings held 2/21/17, 10/20/16 & 7/21/16 included the DON, administrator and other members of the staff. However, there was no medical director or designee in attendance for these three meetings. The meeting form said regarding the medical director/designee "Not	F 520	K520 - The Medical Director was mailed an updated personal service agreement which he will sign and return for our files. The Medical Director has also committed to attending scheduled Quality Assurance meetings in the future. Should the Medical Director not attend the next Quality Assurance Meeting scheduled for August 2017, the Administrator and facility Owner will seek a new Medical Director. The Administrator will monitor the Medical Director's participation in the facility's QA meetings and take appropriate action should the Medical Director not participate in future meetings.	

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F 520	Continued From page 42 available." During an interview on 5/25/17, at 8:38 a.m., regarding the absence of the medical director or designee for meeting held on 2/21/17, 10/20/16 & 7/21/16. The DON stated the facility had called the medical director prior to every meeting. She stated he does not show up. The DON stated if she needs something she sends him a note.	F 520		

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	24E507	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/23/2017**

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SOUTHSIDE CARE CENTER	**2644 ALDRICH AVENUE SOUTH** **MINNEAPOLIS, MN 55408**

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K 000	INITIAL COMMENTS 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Southside Care Center) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 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 (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/22/2017

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

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K 000	Continued From page 1 Angela.Kappenman@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 has a fire sprinkler system throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 17 beds and had a census of 16 at the time of the survey.	K 000		
K 161 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5	K 161		7/23/17

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	24E507	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/23/2017**

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K 161	Continued From page 2 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This STANDARD is not met as evidenced by: Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5	K 161	K161 - Southside Care Center has contracted with Fire Safety Resources, LLC, to have an FSES evaluation conducted to establish that the facility has an overall level of safety	

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 _____	**05/23/2017**

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 161	Continued From page 3 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. Findings Include: On facility tour between 01:00 PM and 04:00 PM on 5/23/17, based on observation revealed that the building construction is Type V (000), which is	K 161	equivalent to that required by the Life Safety Code	

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K 161	Continued From page 4 does not meet the requirement for a 2-story building. This deficient practice was verified by the Facility Maintenance Director 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 161		
K 225 SS=F	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This STANDARD is not met as evidenced by: Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 Findings Include: On facility tour between 01:00 PM and 04:00 PM on 5/23/17, based on observation and interview revealed that the following include: It was observed during a tour of the facility that the back stairs at the rear exit are only 32" wide. The facility has an expired FSES which addresses this deficiency. This deficient practice could affect the safety of all	K 225	K225 - Southside Care Center has contracted with Fire Safety Resources, LLC, to have an FSES evaluation conducted to establish that the facility has an overall level of safety equivalent to that required by the Life Safety Code.	7/23/17

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K 225	Continued From page 5 the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery	K 225		
K 232 SS=F	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This STANDARD is not met as evidenced by: Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Findings Include: On facility tour between 01:00 PM and 04:00 PM on 5/23/17, based on observation and interview revealed that the following include: It was observed during a tour of the facility that the first floor corridor is only 33 inches in clear width and not the 48 inches required for this type of facility. The facility has an expired FSES which addresses this deficiency.	K 232	K232 - Southside Care Center has contracted with Fire Safety Resources, LLC, to have an FSES evaluation conducted to establish that the facility has an overall level of safety equivalent to that required by the Life Safety Code.	7/23/17

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	24E507	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/23/2017**

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K 232	Continued From page 6 This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery	K 232		
K 311 SS=F	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This STANDARD is not met as evidenced by: Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. Findings Include: On facility tour between 01:00 PM and 00400 PM on 5/23/17, based on observation and interview revealed that the following include:	K 311	K0311 - Southside Care Center has contracted with Fire Safety Resources, LLC, to have an FSES evaluation conducted to establish that the facility has an overall level of safety equivalent to that required by the Life Safety Code.	7/23/17

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K 311	Continued From page 7 It was observed during a tour of the facility 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. The facility has an expired FSES which addresses this deficiency. This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery	K 311		
K 712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established	K 712	Plan of correction: The September 27, 2016 and December 29, 2016 Fire Drills were updated to reflect the time of day the drills were conducted. The November 23rd, 2016 Fire Drill was logged on the summary heet but not filed correctly. All	6/16/17

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K 712	Continued From page 8 routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 Findings Include: On facility tour between 01:00 PM and 04:00 PM on 5/23/17, based on documentation review and interview that the following include: Fire drill sheets show no drill for November 23, 2016 and times were missing for September 27, 2016 and December 29, 2016. This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery	K 712	three Fire Drill records were sent to the Fire Marshall for the record. The Administrator will monitor the completion of fire drills on a monthly basis ensuring that the fire drill form(s) are completed in their entirety.	