

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL  
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: PVTX  
Facility ID: 00780

|  |  |   |  |  |  |  |
|--|--|---|--|--|--|--|
| 1. MEDICARE/MEDICAID PROVIDER NO.(L1) <b>24E507</b>  |  | 3. NAME AND ADDRESS OF FACILITY (L3) <b>SOUTHSIDE CARE CENTER</b><br>(L4) <b>2644 ALDRICH AVENUE SOUTH</b><br>(L5) <b>MINNEAPOLIS, MN</b> (L6) <b>55408</b>   |  |  | 4. TYPE OF ACTION: <u>7</u> (L8)<br><br>1. Initial<br>2. Recertification<br>3. Termination<br>4. CHOW<br>5. Validation<br>6. Complaint<br>7. On-Site Visit<br>9. Other<br><br>8. Full Survey After Complaint   |  |
| 2. STATE VENDOR OR MEDICAID NO. (L2) <b>904343800</b>  |  | 5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)  |  |  | 7. PROVIDER/SUPPLIER CATEGORY <u>10</u> (L7)<br><b>01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA</b>  |  |
| 6. DATE OF SURVEY <b>6/14/2016</b> (L34)   |  | 7. PROVIDER/SUPPLIER CATEGORY <u>10</u> (L7)<br><b>02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF</b>   |  |  | 8. ACCREDITATION STATUS: <u>    </u> (L10)<br>0 Unaccredited 1 TJC<br>2 AOA 3 Other  |  |
| 8. ACCREDITATION STATUS: <u>    </u> (L10)<br>0 Unaccredited 1 TJC<br>2 AOA 3 Other                              |  | 7. PROVIDER/SUPPLIER CATEGORY <u>10</u> (L7)<br><b>03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC</b>  |  |  | FISCAL YEAR ENDING DATE: (L35)<br><b>06/30</b>   |  |
| 7. PROVIDER/SUPPLIER CATEGORY <u>10</u> (L7)<br><b>04 SNF 08 OPT/SP 12 RHC 16 HOSPICE</b>                        |  | 10.THE FACILITY IS CERTIFIED AS:<br>A. In Compliance With <u>X</u><br>Program Requirements Compliance Based On:<br><u>    </u> 1. Acceptable POC<br>B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: <b>A, 4, 8</b> (L12) |  |  | And/Or Approved Waivers Of The Following Requirements:<br><u>    </u> 2. Technical Personnel <u>    </u> 6. Scope of Services Limit<br><u>    </u> 3. 24 Hour RN <u>    </u> 7. Medical Director<br><u>X</u> 4. 7-Day RN (Rural SNF) <u>X</u> 8. Patient Room Size<br><u>    </u> 5. Life Safety Code <u>    </u> 9. Beds/Room |  |
| 11. LTC PERIOD OF CERTIFICATION<br>From (a) :<br>To (b) :  |  | 12.Total Facility Beds <b>17</b> (L18)<br>13.Total Certified Beds <b>17</b> (L17)   |  |  | 14. LTC CERTIFIED BED BREAKDOWN<br>18 SNF 18/19 SNF 19 SNF ICF IID<br><b>17</b><br>(L37) (L38) (L39) (L42) (L43)   |  |
| 14. LTC CERTIFIED BED BREAKDOWN<br>18 SNF 18/19 SNF 19 SNF ICF IID<br><b>17</b><br>(L37) (L38) (L39) (L42) (L43) |  | 15. FACILITY MEETS<br>1861 (e) (1) or 1861 (j) (1): (L15)   |  |  |  |  |

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

See Attached Remarks

|  |  |                        |   |  |                       |
|--|--|------------------------|---|--|-----------------------|
| 17. SURVEYOR SIGNATURE<br><br><u>Gloria Derfus, Unit Supervisor</u><br>(L19) |  | Date :<br><br>9/8/2016 | 18. STATE SURVEY AGENCY APPROVAL<br><br><u>Kamala Fiske-Downing, Health Program Representative</u><br>(L20) |  | Date:<br><br>9/9/2016 |
|--|--|------------------------|---|--|-----------------------|

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

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 19. DETERMINATION OF ELIGIBILITY<br><u>X</u> 1. Facility is Eligible to Participate<br><u>    </u> 2. Facility is not Eligible (L21) |  | 20. COMPLIANCE WITH CIVIL RIGHTS ACT:  |  | 21. 1. Statement of Financial Solvency (HCFA-2572)<br>2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)<br>3. Both of the Above : <u>    </u>   |  |
| 22. ORIGINAL DATE OF PARTICIPATION <b>01/26/1978</b> (L24)   |  | 23. LTC AGREEMENT BEGINNING DATE (L41)   |  | 24. LTC AGREEMENT ENDING DATE (L25)   |  |
| 25. LTC EXTENSION DATE: (L27)  |  | 27. ALTERNATIVE SANCTIONS<br>A. Suspension of Admissions: (L44)<br>B. Rescind Suspension Date: (L45) |  | 26. TERMINATION ACTION: (L30)<br><b>VOLUNTARY</b> <u>00</u> <b>INVOLUNTARY</b><br>01-Merger, Closure 05-Fail to Meet Health/Safety<br>02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement<br>03-Risk of Involuntary Termination <u>OTHER</u><br>04-Other Reason for Withdrawal 07-Provider Status Change<br>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 <b>08/31/2016</b> (L33)   |  | DETERMINATION APPROVAL  |  |

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

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

F354 -42 CFR 483.30(b) - Seven day registered nurse coverage

F458-42 CFR 483.70(d)(1)(ii)-Resident room size requirements

On August 31, 2016 the Minnesota Department of Public Safety completed to a Post Certification Revisit (PCR) to verify your facility had achieved and maintain compliance with Federal certification deficiencies issued pursuant to the FMS survey completed May 2, 2016. Based on our PCR, we have determined that your facility has corrected deficiencies pursuant to the FMS completed May 2, 2016.

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



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 24E507

September 9, 2016

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

Dear Mr. Musser:

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.

Effective July 29, 2016 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.

Your request for waiver of tags 0354 and 0458 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

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.

Southside Care Center

September 9, 2016

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A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive style with a distinct loop for the letter 'F'.

Kamala Fiske-Downing

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: [Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)





PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

September 8, 2016

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

RE: Project Number SE507025

Dear Mr. Musser:

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

On May 5, 2016 we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 21, 2016. The survey found the most serious deficiencies in the facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E).

On May 18, 2016 a surveyor representing this office of the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. The FMS found additional deficiencies. In the letter dated May 18, 2016, CMS informed you that your facility continues to not be in substantial compliance.

On June 14, 2016 the Minnesota Department of Health completed a revisit, by review of your plan of correction, to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 21, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies. Based on our visit, we have determined that your facility has achieved substantial compliance with the **health deficiencies** issued pursuant to our standard survey, completed on April 21, 2016.

However, compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the April 21, 2016 standard survey and the Federal Monitoring Survey (FMS) deficiencies issued pursuant to the May 2, 2016 had not yet been verified.

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 July 21, 2016. (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 July 21, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 21, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Also, we notified you in our letter of June 23, 2016, 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 July 21, 2016.

On August 31, 2016 the Minnesota Department of Public Safety and the Centers for Medicare & Medicaid Services (CMS) completed Post Certification Revisits (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies. Based on our revisits, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 21, 2016 and the LSC and FMS surveys completed on August 31, 2016, as of July 29, 2016.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of June 23, 2016. 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 July 21, 2016, be discontinued effective July 29, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective July 21, 2016, is to be discontinued. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective July 21, 2016, is to be discontinued.

In our letter of June 23, 2016, we advised you that, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 21, 2016, due to denial of payment for new admissions.

Your request for a continuing waiver involving the deficiencies cited under 354 and 458 at the time of the April 21, 2016 standard survey has been forwarded to CMS for their review and determination.

Southside Care Center

September 8, 2016

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Your facility's compliance is based on pending CMS approval of your request for waiver.

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

Feel free to contact me if you have questions.

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive style with a small dot above the 'i' in Downing.

Kamala Fiske-Downing  
Minnesota Department of Health  
Licensing and Certification Program  
Program Assurance Unit  
Health Regulation Division  
85 East Seventh Place, Suite 220  
St. Paul, MN 55164-0900  
Telephone: (651) 201-4112 Fax: (651) 215-9697  
Email: [Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7013 3020 0001 8869 1012

June 23, 2016

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

RE: Project Number SE507025

Dear Mr. Musser:

On May 5, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 21, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 14, 2016 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 21, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies. Based on our visit, we have determined that your facility has achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on April 21, 2016.

However, compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the April 21, 2016 standard survey has not yet been verified. The most serious LSC deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

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 July 21, 2016. (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 July 21, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 21, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(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 a denial of payment. Therefore, Southside Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 21, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, 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.

Your request for continuing waivers involving the deficiencies cited under F354 and F458 at the time of the April 21, 2016 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

A copy of the Post Certification Revisit Form (CMS-2567B) from the April 21, 2016 revisit is enclosed.

## **APPEAL RIGHTS**

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

[Tamika.Brown@cms.hhs.gov](mailto:Tamika.Brown@cms.hhs.gov)

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later

Southside Care Center

June 21, 2016

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than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services  
Departmental Appeals Board, MS 6132  
Director, Civil Remedies Division  
330 Independence Avenue, S.W.  
Cohen Building – Room G-644  
Washington, D.C. 20201  
(202) 565-9462

A request for a hearing should identify the specific issues, 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. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at [Tamika.Brown@cms.hhs.gov](mailto:Tamika.Brown@cms.hhs.gov).

#### **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 October 21, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### **INFORMAL DISPUTE RESOLUTION**

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

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

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

Southside Care Center

June 21, 2016

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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](mailto:tom.linhoff@state.mn.us)  
Telephone: (651) 430-3012  
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing, Program Specialist  
Licensing and Certification Program  
Health Regulation Division  
Minnesota Department of Health  
[Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)  
Telephone: (651) 201-4112  
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

## POST-CERTIFICATION REVISIT REPORT

|  |    |   |   |                              |    |
|--|----|---|---|------------------------------|----|
| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER<br>24E507 | Y1 | MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing | Y2  | DATE OF REVISIT<br>6/14/2016 | Y3 |
| NAME OF FACILITY<br>SOUTHSIDE CARE CENTER                    |    |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2644 ALDRICH AVENUE SOUTH<br>MINNEAPOLIS, MN 55408 |                              |    |

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

| ITEM<br>Y4                 | DATE<br>Y5 | ITEM<br>Y4       | DATE<br>Y5 | ITEM<br>Y4          | DATE<br>Y5 |
|----------------------------|------------|------------------|------------|---------------------|------------|
| ID Prefix F0431            | Correction | ID Prefix F0465  | Correction | ID Prefix F0466     | Correction |
| Reg. # 483.60(b), (d), (e) | Completed  | Reg. # 483.70(h) | Completed  | Reg. # 483.70(h)(1) | Completed  |
| LSC                        | 05/17/2016 | LSC              | 06/03/2016 | LSC                 | 05/12/2016 |
| ID Prefix                  | Correction | ID Prefix        | Correction | ID Prefix           | Correction |
| Reg. #                     | Completed  | Reg. #           | Completed  | Reg. #              | Completed  |
| LSC                        |            | LSC              |            | LSC                 |            |
| ID Prefix                  | Correction | ID Prefix        | Correction | ID Prefix           | Correction |
| Reg. #                     | Completed  | Reg. #           | Completed  | Reg. #              | Completed  |
| LSC                        |            | LSC              |            | LSC                 |            |
| ID Prefix                  | Correction | ID Prefix        | Correction | ID Prefix           | Correction |
| Reg. #                     | Completed  | Reg. #           | Completed  | Reg. #              | Completed  |
| LSC                        |            | LSC              |            | LSC                 |            |
| ID Prefix                  | Correction | ID Prefix        | Correction | ID Prefix           | Correction |
| Reg. #                     | Completed  | Reg. #           | Completed  | Reg. #              | Completed  |
| LSC                        |            | LSC              |            | LSC                 |            |
| ID Prefix                  | Correction | ID Prefix        | Correction | ID Prefix           | Correction |
| Reg. #                     | Completed  | Reg. #           | Completed  | Reg. #              | Completed  |
| LSC                        |            | LSC              |            | LSC                 |            |

|   |                                  |  |                                |                   |
|---|----------------------------------|--|--------------------------------|-------------------|
| REVIEWED BY STATE AGENCY <input type="checkbox"/> | REVIEWED BY (INITIALS)<br>GD/kfd | DATE<br>9/8/2016   | SIGNATURE OF SURVEYOR<br>18623 | DATE<br>6/14/2016 |
| REVIEWED BY CMS RO <input type="checkbox"/>       | REVIEWED BY (INITIALS)           | DATE   | TITLE                          | DATE              |
| FOLLOWUP TO SURVEY COMPLETED ON<br>4/21/2016      |                                  | <input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO |                                |                   |



## POST-CERTIFICATION REVISIT REPORT

|  |    |   |   |                              |    |
|--|----|---|---|------------------------------|----|
| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER<br>24E507 | Y1 | MULTIPLE CONSTRUCTION<br>A. Building 01 - MAIN BUILDING 01<br>B. Wing | Y2  | DATE OF REVISIT<br>8/31/2016 | Y3 |
| NAME OF FACILITY<br>SOUTHSIDE CARE CENTER                    |    |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2644 ALDRICH AVENUE SOUTH<br>MINNEAPOLIS, MN 55408 |                              |    |

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

| ITEM<br>Y4      | DATE<br>Y5 | ITEM<br>Y4      | DATE<br>Y5 | ITEM<br>Y4      | DATE<br>Y5 |
|-----------------|------------|-----------------|------------|-----------------|------------|
| ID Prefix _____ | Correction | ID Prefix _____ | Correction | ID Prefix _____ | Correction |
| Reg. # NFPA 101 | Completed  | Reg. # NFPA 101 | Completed  | Reg. # NFPA 101 | Completed  |
| LSC K0012       | 07/13/2016 | LSC K0033       | 07/13/2016 | LSC K0034       | 07/13/2016 |
| ID Prefix _____ | Correction | ID Prefix _____ | Correction | ID Prefix _____ | Correction |
| Reg. # NFPA 101 | Completed  | Reg. # _____    | Completed  | Reg. # _____    | Completed  |
| LSC K0039       | 07/13/2016 | LSC _____       |            | LSC _____       |            |
| ID Prefix _____ | Correction | ID Prefix _____ | Correction | ID Prefix _____ | Correction |
| Reg. # _____    | Completed  | Reg. # _____    | Completed  | Reg. # _____    | Completed  |
| LSC _____       |            | LSC _____       |            | LSC _____       |            |
| ID Prefix _____ | Correction | ID Prefix _____ | Correction | ID Prefix _____ | Correction |
| Reg. # _____    | Completed  | Reg. # _____    | Completed  | Reg. # _____    | Completed  |
| LSC _____       |            | LSC _____       |            | LSC _____       |            |
| ID Prefix _____ | Correction | ID Prefix _____ | Correction | ID Prefix _____ | Correction |
| Reg. # _____    | Completed  | Reg. # _____    | Completed  | Reg. # _____    | Completed  |
| LSC _____       |            | LSC _____       |            | LSC _____       |            |

|   |                                  |  |                                    |                   |
|---|----------------------------------|--|------------------------------------|-------------------|
| REVIEWED BY STATE AGENCY <input type="checkbox"/> | REVIEWED BY (INITIALS)<br>TL/kfd | DATE<br>9/8/2016   | SIGNATURE OF SURVEYOR<br><br>37009 | DATE<br>8/31/2016 |
| REVIEWED BY CMS RO <input type="checkbox"/>       | REVIEWED BY (INITIALS)           | DATE   | TITLE                              | DATE              |
| FOLLOWUP TO SURVEY COMPLETED ON<br>4/21/2016      |                                  | <input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO |                                    |                   |

## POST-CERTIFICATION REVISIT REPORT

|  |   |                              |
|--|---|------------------------------|
| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER<br>24E507 | MULTIPLE CONSTRUCTION<br>A. Building 01 - MAIN BUILDING 01<br>B. Wing                       | DATE OF REVISIT<br>8/31/2016 |
| NAME OF FACILITY<br>SOUTHSIDE CARE CENTER                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2644 ALDRICH AVENUE SOUTH<br>MINNEAPOLIS, MN 55408 |                              |

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

| ITEM<br>Y4  | DATE<br>Y5                            | ITEM<br>Y4   | DATE<br>Y5                            | ITEM<br>Y4                                      | DATE<br>Y5                            |
|---|---------------------------------------|--|---------------------------------------|---|---------------------------------------|
| ID Prefix _____<br>Reg. # NFPA 101<br>LSC K0012   | Correction<br>Completed<br>07/13/2016 | ID Prefix _____<br>Reg. # NFPA 101<br>LSC K0033  | Correction<br>Completed<br>07/13/2016 | ID Prefix _____<br>Reg. # NFPA 101<br>LSC K0038 | Correction<br>Completed<br>07/13/2016 |
| ID Prefix _____<br>Reg. # NFPA 101<br>LSC K0050   | Correction<br>Completed<br>05/03/2016 | ID Prefix _____<br>Reg. # NFPA 101<br>LSC K0052  | Correction<br>Completed<br>06/27/2016 | ID Prefix _____<br>Reg. # NFPA 101<br>LSC K0054 | Correction<br>Completed<br>05/12/2016 |
| ID Prefix _____<br>Reg. # NFPA 101<br>LSC K0056   | Correction<br>Completed<br>07/07/2016 | ID Prefix _____<br>Reg. # NFPA 101<br>LSC K0062  | Correction<br>Completed<br>06/23/2016 | ID Prefix _____<br>Reg. # NFPA 101<br>LSC K0069 | Correction<br>Completed<br>07/29/2016 |
| ID Prefix _____<br>Reg. # NFPA 101<br>LSC K0074   | Correction<br>Completed<br>05/03/2016 | ID Prefix _____<br>Reg. # NFPA 101<br>LSC K0147  | Correction<br>Completed<br>06/30/2016 | ID Prefix _____<br>Reg. # _____<br>LSC _____    | Correction<br>Completed<br>_____      |
| ID Prefix _____<br>Reg. # _____<br>LSC _____      | Correction<br>Completed<br>_____      | ID Prefix _____<br>Reg. # _____<br>LSC _____   | Correction<br>Completed<br>_____      | ID Prefix _____<br>Reg. # _____<br>LSC _____    | Correction<br>Completed<br>_____      |
| REVIEWED BY STATE AGENCY <input type="checkbox"/> | REVIEWED BY (INITIALS)<br>TI /kfd     | DATE<br>9/8/2016   | SIGNATURE OF SURVEYOR<br>37009        | DATE<br>8/31/2016                               |                                       |
| REVIEWED BY CMS RO <input type="checkbox"/>       | REVIEWED BY (INITIALS)                | DATE   | TITLE                                 | DATE  |                                       |
| FOLLOWUP TO SURVEY COMPLETED ON<br>5/2/2016       |                                       | <input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO |                                       |   |                                       |

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL  
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: PVTX  
Facility ID: 00780

|   |  |   |  |  |   |  |
|---|--|---|--|--|---|--|
| 1. MEDICARE/MEDICAID PROVIDER NO.(L1) <b>24E507</b>       |  | 3. NAME AND ADDRESS OF FACILITY (L3) <b>SOUTHSIDE CARE CENTER</b><br>(L4) <b>2644 ALDRICH AVENUE SOUTH</b><br>(L5) <b>MINNEAPOLIS, MN</b> (L6) <b>55408</b>   |  |  | 4. TYPE OF ACTION: <u>2</u> (L8)<br><br>1. Initial                      2. Recertification<br>3. Termination              4. CHOW<br>5. Validation                 6. Complaint<br>7. On-Site Visit              9. Other<br><br>8. Full Survey After Complaint |  |
| 2. STATE VENDOR OR MEDICAID NO. (L2) <b>904343800</b>     |  | 5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)  |  |  | 7. PROVIDER/SUPPLIER CATEGORY <u>10</u> (L7)<br><b>01 Hospital      05 HHA      09 ESRD      13 PTIP      22 CLIA</b>   |  |
| 6. DATE OF SURVEY <b>04/21/2016</b> (L34)                 |  | 8. ACCREDITATION STATUS: <u>    </u> (L10)<br>0 Unaccredited      1 TJC<br>2 AOA                      3 Other   |  |  | FISCAL YEAR ENDING DATE: (L35)<br><b>06/30</b>  |  |
| 11. LTC PERIOD OF CERTIFICATION<br>From (a) :<br>To (b) : |  | 10. THE FACILITY IS CERTIFIED AS:<br>A. In Compliance With Program Requirements Compliance Based On:<br><u>    </u> 1. Acceptable POC<br><br>X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: <b>B, 4, 8</b> (L12)<br><u>And/Or Approved Waivers Of The Following Requirements:</u><br><u>    </u> 2. Technical Personnel <u>    </u> 6. Scope of Services Limit<br><u>    </u> 3. 24 Hour RN <u>    </u> 7. Medical Director<br><input checked="" type="checkbox"/> 4. 7-Day RN (Rural SNF) <input checked="" type="checkbox"/> 8. Patient Room Size<br><u>    </u> 5. Life Safety Code <u>    </u> 9. Beds/Room |  |  |   |  |
| 12. Total Facility Beds <b>17</b> (L18)                   |  | 14. LTC CERTIFIED BED BREAKDOWN<br>18 SNF      18/19 SNF      19 SNF      ICF      IID<br><b>17</b><br>(L37)      (L38)      (L39)      (L42)      (L43)  |  |  | 15. FACILITY MEETS<br>1861 (e) (1) or 1861 (j) (1): (L15)   |  |
| 13. Total Certified Beds <b>17</b> (L17)                  |  | 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):<br><b>See Attached Remarks</b>  |  |  |   |  |

|  |  |                      |   |  |                     |
|--|--|----------------------|---|--|---------------------|
| 17. SURVEYOR SIGNATURE<br><u>Carrie Euerle, HFE NE II</u><br>(L19) |  | Date :<br>07/20/2016 | 18. STATE SURVEY AGENCY APPROVAL<br><u>Kamala Fiske-Downing, Health Program Representative</u><br>(L20) |  | Date:<br>08/31/2016 |
|--|--|----------------------|---|--|---------------------|

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

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 19. DETERMINATION OF ELIGIBILITY<br><input checked="" type="checkbox"/> 1. Facility is Eligible to Participate<br><u>    </u> 2. Facility is not Eligible<br>(L21) |  | 20. COMPLIANCE WITH CIVIL RIGHTS ACT:  |  | 21. 1. Statement of Financial Solvency (HCFA-2572)<br>2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)<br>3. Both of the Above : <u>    </u>  |  |
| 22. ORIGINAL DATE OF PARTICIPATION <b>01/26/1978</b><br>(L24)  |  | 23. LTC AGREEMENT BEGINNING DATE<br>(L41)  |  | 24. LTC AGREEMENT ENDING DATE<br>(L25)   |  |
| 25. LTC EXTENSION DATE: (L27)  |  | 27. ALTERNATIVE SANCTIONS<br>A. Suspension of Admissions: (L44)<br>B. Rescind Suspension Date: (L45) |  | 26. TERMINATION ACTION: (L30)<br><u>VOLUNTARY</u> <u>00</u> <u>INVOLUNTARY</u><br>01-Merger, Closure                      05-Fail to Meet Health/Safety<br>02-Dissatisfaction W/ Reimbursement      06-Fail to Meet Agreement<br>03-Risk of Involuntary Termination <u>OTHER</u><br>04-Other Reason for Withdrawal              07-Provider Status Change<br>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 <b>08/31/2016</b><br>(L33)  |  | DETERMINATION APPROVAL   |  |

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

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Page 2

24E507

At the time of the standard survey completed April 21,2016 the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS- 2567 for survey results. Post Certification Revisit to follow.

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

F354 -42 CFR 483.30(b) - Seven day registered nurse coverage

F458-42 CPR 483.70(d)(l)(ii)-Resident room size requirements

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PVTX

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
4. TYPE OF ACTION: 2 (L8)
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY 04/21/2016 (L34)
7. PROVIDER/SUPPLIER CATEGORY 10 (L7)
8. ACCREDITATION STATUS: (L10)
9. LTC PERIOD OF CERTIFICATION
10. THE FACILITY IS CERTIFIED AS:
11. LTC CERTIFIED BED BREAKDOWN
12. Total Facility Beds 17 (L18)
13. Total Certified Beds 17 (L17)
14. LTC CERTIFIED BED BREAKDOWN
15. FACILITY MEETS
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date: 07/20/2016
18. STATE SURVEY AGENCY APPROVAL Date: 08/31/2016
See Attached Remarks
Carrie Euerle, HFE NE II (L19)
Kamala Fiske-Downing, Health Program Representative (L20)

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

19. DETERMINATION OF ELIGIBILITY
20. COMPLIANCE WITH CIVIL RIGHTS ACT:
21. 1. Statement of Financial Solvency (HCFA-2572)
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)
26. TERMINATION ACTION: 00 (L30)
27. ALTERNATIVE SANCTIONS
28. TERMINATION DATE: (L28)
29. INTERMEDIARY/CARRIER NO. (L31)
30. REMARKS
31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE 08/31/2016 (L33)
DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

Page 2

24E507

At the time of the standard survey completed April 21,2016 the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS- 2567 for survey results. Post Certification Revisit to follow.

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

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

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



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 5941  
May 5, 2016

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

RE: Project Number SE507025

Dear Mr. Musser:

On April 21, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

**Opportunity to Correct** - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

**Remedies** - the type of remedies that will be imposed with the authorization of the

**Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

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

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

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

## **DEPARTMENT CONTACT**

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

**Gloria Derfus, Unit Supervisor  
Minnesota Department of Health  
Health Regulation Division  
P.O. Box 64900  
St. Paul, Minnesota 55164-0970  
Telephone: (651) 201-3792  
Fax: (651) 201-3790**

## **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 31, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 31, 2016 the following remedy will be imposed:

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

## **PLAN OF CORRECTION (PoC)**

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



- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

#### **PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

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

## **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

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

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

### **Original deficiencies not corrected**

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

### **Original deficiencies not corrected and new deficiencies found during the revisit**

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

### **Original deficiencies corrected but new deficiencies found during the revisit**

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

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

If substantial compliance with the regulations is not verified by July 21, 2016 (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

Southside Care Center

May 5, 2016

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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 October 21, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

### **INFORMAL DISPUTE RESOLUTION**

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

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

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: [http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\\_idr.cfm](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  
444 Minnesota Street, Suite 145  
St. Paul, Minnesota 55101-5145  
Email: [tom.linhoff@state.mn.us](mailto:tom.linhoff@state.mn.us)  
Telephone: (651) 430-3012  
Fax: (651) 215-0525**

Southside Care Center

May 5, 2016

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Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Kate Johnston". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Kate JohnsTon, Program Specialist  
Program Assurance Unit  
Licensing and Certification Program  
Health Regulation Division  
85 East Seventh Place, Suite 220  
P.O. Box 64900  
St. Paul, Minnesota 55164-0900  
kate.johnston@state.mn.us  
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

*Received 6/13/16*

PRINTED: 05/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>24E507</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>04/21/2016</b> |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SOUTHSIDE CARE CENTER</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2644 ALDRICH AVENUE SOUTH<br/>MINNEAPOLIS, MN 55408</b> |
|--|---|

| (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<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance.<br><br>Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.   | F 000 |  |  |
| F 354<br>SS=F | 483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON<br><br>Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.<br><br>Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.<br><br>The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure a full time registered nurse (RN) was employed for eight consecutive hours a day, seven days per week. This had the potential to affect 16 of 16 residents in the facility. | F354  | F354 - Southside Care Center has employed an Registered Nurse as the Director of Nursing and Program Manager/ Charge Nurse five days/week for 8 hours/day. Southside has for many years had a waiver granted for this requirement and only during the most recent survey were they advised that Minnesota no longer has the option to request a waiver. As a result, Southside has begun a recruitment effort to hire a part time Register Nurse to cover 8 hours on Saturday and Sunday. In the interim, the current DON has been available on call or worked a weekend shift when required to fill in. |  |

*Accepted 6-13-16  
Jennifer*

|  |                               |                               |
|--|-------------------------------|-------------------------------|
| LABORATORY DIRECTOR'S OR APPROVED/CLIA IDENTIFIED REPRESENTATIVE'S SIGNATURE<br><br><i>Stephen J. Munn</i> | TITLE<br><b>Administrator</b> | (X6) DATE<br><b>5/19/2016</b> |
|--|-------------------------------|-------------------------------|

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

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

PRINTED: 05/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

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| F 354  | Continued From page 1<br>Findings include:<br><br>On 4/19/16 at 4:26 p.m. the director of nursing (DON) was interviewed and stated she was the only registered nurse (RN) for the building and that there was not 24 hour nursing coverage. The DON stated that she was the only RN employed at the facility and the residents at the facility do not need 24 hour nursing care. The DON went on to say that during the night there was only one full-time licensed practical nurse (LPN) employed, otherwise the facility has a trained medication aide (TMA) to work overnight. The DON stated that she was on-call for the facility 24/7.<br><br>On 4/21/16, at 8:38 a.m. the DON and administrator confirmed there the DON was the only RN employed at the facility and there was not RN coverage on the weekends.<br><br>On 4/21/16, at 9:34 a.m. staff schedules were reviewed for the last month and revealed there was not RN coverage on the weekends (Saturday-Sunday) and there was not an RN working 8 hours per day 7 days per week. | F 354   | Advertisements have been placed in Beyond.com and Indeed.com to fill this vacancy. The goal will be to fill these shifts within 30 days.<br><br>In the interim, Southside Care Center requests a partial waiver from this requirement. Southside is a Board and Care facility where each resident is ambulatory. Currently, an LPN is scheduled for one shift on each weekend day with on call availability by the DON. See Attachment B - Waiver Request | 6/18/16<br>OB<br>6-16 |   |
| F 431<br>SS=D  | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be  | F 431   | F431 - Southside Care Center employs the services of Omnicare Pharmacy for all controlled drugs, records, receipts and consults.  |                       |   |

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| F 431  | <p>Continued From page 2</p> <p>labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview and document review, the facility failed to ensure expired medications were not given to 2 of 2 residents (R10, R4) reviewed for medication storage.</p> <p>Findings include:</p> <p>R10<br/>On 4/19/16, at 4:24 p.m. during medication storage observation, a Novolog insulin (a medication for the treatment of diabetes) FlexPen was observed in the top drawer of the medication cart that was labeled with R10's name and as</p> | F 431   | <p>All nurses and TMA's have been provided with additional education regarding disposal of expired and/or discontinued medication as 5/17/16.</p> <p>All TMA's and licenses personnel are required to act under facility policy regarding and environmental regulation applied to the destruction medication.</p> <p>The policy includes reviewing the manufacturers expiration dates and notating shell/ storage expiration dates for varied medication including but not limited to inhalers, eye drops, and insulins.</p> <p>The Omnicare Pharmacy policy and procedure is placed in front of the MAR in access to all qualified personnel.</p> | 5/17/16              |   |

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| F 431  | <p>Continued From page 3<br/>opened on 3/5/16, and expired on 4/7/16.</p> <p>On 4/19/16, at 4:36 p.m. licensed practical nurse (LPN)-A was observed putting the Novolog insulin (a medication for the treatment of diabetes) FlexPen on shelf above nurses desk. The area was open to the corridor between the kitchen and the dining room, and directly across from resident room 102. From 5:30 to 6:00 p.m. R14 and registered nurse (RN)-A walked between the kitchen and the dining room delivering supper trays. At 6:00 p.m. the Novolog FlexPen was visible on shelf over the nurse's desk. At 7:08 p.m. the Novolog insulin FlexPen was no longer on shelf over the nurse's desk</p> <p>R10's quarterly Minimum Data Set (MDS) dated 3/2/16, indicated R10 had diagnosis of diabetes. The MDS indicated R10 had received insulin injections seven out of seven days.</p> <p>The Physician's Orders signed 3/3/16, indicated R10 was to have blood sugars (BS) checked three times a day before meals and receive Novolog insulin as needed based on a sliding scale. For BS=200-250 give two units, BS=251-300 give four units, BS=301-350 give six units, BS =351-400 give eight units, BS=401-450 give ten units, BS =451-500 give 12 units.</p> <p>A review of April 2016, Medication Administration Record (MAR) indicated R10 received two units of NovoLog insulin on 4/14/16, at 11:30 a.m. for BS of 222.</p> <p>On 4/19/16, at 4:30 p.m. LPN-A verified the Novolog FlexPen was dated opened on 3/5/16, and 4/7/16, was written as the date that the FlexPen expired. LPN-A also verified the MAR</p> | F 431   | <p>Southside has identified a seperately locked, permanently affixed compartment for storage of drugs to be discarded. This location will be under the supervision of the Director or Nursing. Use will begin immediately.</p> | 5/17/16              |   |



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| F 431  | <p>Continued From page 4 indicated R10 had received 2 units of insulin on 4/14/16.</p> <p>R4<br/>On 4/19/16, at 4:24 p.m. during medication storage observation, an Advair Diskus 500-50 micrograms (mcg) inhaler (a inhaled steroid for the treatment of respiratory disease) was observed in the top drawer of the medication cart that was labeled with R4's name and as opened on 3/16/16. The counter on the disk indicated that were 30 doses left in the inhaler. On 4/19/16, at 4:30 p.m. LPN-A verified the Advair inhaler was dated as opened on 3/16/16, and indicated it did not expire until 8/2017, or all doses were used.</p> <p>On 4/20/16, at 8:15 a.m. trained medication aide (TMA)-A was observed to give R4 an inhaler at the dining room table per R4's request. When TMA-A brought the inhaler back to the medication cart TMA-A showed surveyor that the in haler was Advair Diskus 500-50 mcg dated opened 3/16/16, with 29 doses left. When TMA-A was asked how long Advair Diskus was good for after being removed from foil package, TMA-A said, "Let me ask my nurse." TMA-A verified there was an unopened Advair Diskus for R4 in the medication cart. The director of nurses (DON) stated, "I do not know when it expires let me find out."</p> <p>R4's quarterly MDS dated 3/16/16, indicated R10 had diagnosis of chronic obstructive pulmonary disease. The Physician Orders signed 3/3/16, instructed staff that R4 was to receive Advair Diskus 500-50 micrograms (mcg), one puff twice a day and to rinse mouth after use.</p> <p>During interview on 4/20/16, at 8:30 a.m. the</p> | F 431   |   |                      |   |

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| F 431  | <p>Continued From page 5</p> <p>DON stated per pharmacy Advair Diskus was good for 45 days after it was removed from the foil package. Requested copy of pharmacy policy.</p> <p>During interview on 4/20/16, at 9:09 a.m. the DON provided copy of Omnicare Recommended Minimum Medication Storage Parameters revised 3/31/15. RN-A verified that Advair Diskus was to be discarded 30 days after foil package was opened but stated medication was not expired. DON stated thought the Novolog was discontinued. DON acknowledged that the NovoLog was expired prior to 4/14/16, when it was last used. DON stated, "I expect all nurses and TMA's to check expiration dates and remove expired medications from the cart and dispose of them properly."</p> <p>Omicare Recommended Minimum Medication Storage Parameters revised 3/31/15, indicated staff regarding Advair Diskus "Store between 68-77 [degrees Fahrenheit] (20-25 degrees (Celsius) in a dry place. Date the Diskus when removed from the foil pouch and discard 1 month after removal from foil pouch or after all blisters have been used, whichever comes first."</p> <p>Omicare Insulin Storage Recommendations revised 3/15/16, instructed staff that insulin cartridge or pens expire 28 days after being opened.</p> <p>Medication administration dated March 2013, instructed staff, "Medications that are to be discarded will be sorted by hazardous and non-hazardous categories and placed in the appropriate bins. The bins are stored in a locked area and are picked -up regularly by a licensed hauler."</p> | F 431   |   |                      |   |

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| F 431  | Continued From page 6<br><br>The package insert for the NovoLog Flexpen from Novo Nordisk dated April 2015, directed the user to: "Do keep NovoLog FlexPen at temperatures below 86°F (30°C) for up to 28 days once it is punctured."<br><br>The package insert for Advair Diskus from GlaxoSmithKline dated April 2014, directed the user to:<br>· "Store ADVAIR DISKUS at room temperature between 68°F and 77°F (20°C and 25°C). Keep in a dry place away from heat and sunlight.<br>· Store ADVAIR DISKUS in the unopened foil pouch and only open when ready for use.<br>· Safely throw away ADVAIR DISKUS in the trash 1 month after you open the foil pouch or when the counter reads 0, whichever comes first." | F 431   |   |                      |   |
| F 458<br>SS=D  | 483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT<br><br>Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to provide at least 80 square feet of usable space in 1 of 6 resident bedrooms occupied by four residents (R5, R11, R12, R13).<br><br>Findings include:<br><br>Observation of the room occupied by R5, R11,   | F 458   | See attachment A - Room Size Waiver Request.  | 5/19/16              |   |

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| F 458  | Continued From page 7<br>R12, and R13 on 2/9/15, at 3:00 p.m. revealed the room contained a dresser and wardrobe for each resident. The usable floor space of the room was 310 square feet, which provided 77.5 square feet per resident.   | F 458   |   |                      |   |
| F 465<br>SS=F  | On 4/19/16, at 4:24 p.m. R11 denied concerns with room size stating she liked her area and there was no problem with the size of her room. On 4/19/16, at 1:50 p.m., R12 denied any concerns with room size or accommodations. R5 and R13 declined all interviews during the survey.<br>483.70(h)<br>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure resident rooms, hallways, common areas and bathrooms were maintained in a safe and sanitary manner. This had the potential to affect all 16 residents residing in the facility.<br><br>Findings include:<br><br>Flooring:<br>Resident room 102 had six areas of carpet that were detached from the surface of the floor causing the carpet to be raised. The first area was approximately 2 feet long and 1 foot from the entrance to the door. Four residents resided in | F 465   | <b>F465 - SouthsideCare Center makes every effort to ensure that residents have a safe and clean environment.</b><br><br>Disinfectant wipes have been made available to residents who have requested them to be available. We will continue to monitor resident concerns raised individually or through the Resident Council. | Ongoing              |   |

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| F 465  | <p>Continued From page 8<br/>room 102, R13, R11, R12 and R5.</p> <p>R13's care plan dated 1/28/15, indicated she was at high risk for falls related to paraplegia, confusion, and balance/gait problems. The care plan indicated, "the resident needs a safe environment with: even floors free from spills and/or clutter." R13's care plan dated 1/14/15, identified her at risk for falls related to history of hip fracture and indicated "the resident needs a safe environment with: even floors free from spills and/or clutter." R5's care plan dated 3/17/15, identified limited physical mobility, use of a cane and use of walls for locomotion.</p> <ul style="list-style-type: none"> <li>- The front entry had two rugs, approximately 2 feet by three feet. Sand and dirt were present between the rugs and the door transitions.</li> <li>- The carpeting on the stairs leading up from the front entrance was visibly soiled.</li> <li>- The entrance at the back of the facility contained a wet floor sign that was coated with black grime. The transition strip was also coated with black dirt.</li> <li>- The stairs leading to the second level from the rear entrance of the facility were stained black with dirt. The walls had multiple cracks and a triangular shaped hole approximately one half inch in length. At the top of the stairs the carpet was stained black. The door and window frames and the sprinkler pipes contained approximately one quarter inch of dust on the tops.</li> <li>- The second floor hallway had a rocking chair in front of the window. The rockers on the bottom of the chair had black dirt covering the tops. In front</li> </ul> | F 465   | <p>The carpet in Room 102 across from the Program Managers/DON's desk has been scheduled to be replaced with a new floor. A contract has been consumated with Home Depot - Order # H2808-9422 to be scheduled and completed by June 3rd.</p> <p>This carpet is the source of much of the odors on that area of the building and will be a cleaner and easier surface to maintain.</p> <p>This same contract will replace the carpet in the back stairwell and second floor landing.</p> <p>This carpet has been difficult to clean and will be replaced by June 3rd.</p> <p>For both - See attachment J Southside has contacted carpet cleaners to clean the carpets in Room 101 and the front stairway. These carpets are in fair condition and a cleaning will assist in removing and existing dirt and odors. This will be completed by May 23rd..</p> | 6/3/16               | 6/3/16  | 5/23/16 |

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| F 465   | Continued From page 9 of the rocking chair was a portable radio coated in dust.<br><br>- The main entrance of the facility was covered in a wood grain flooring. The flooring had a crack approximately two feet in length.<br><br>- The bottom of the entry door to room 101 was chipped with dirt coating the door casing. All of the resident room doors had a black/brown grime coating the door casings and trim.<br><br>A subsequent environmental tour was completed with the owner of the facility on 4/20/16, at 10:16 a.m. The owner acknowledged the environmental concerns and stated, the plaster needs to be repaired and painted and the carpet needs replacing. He stated "replacing the carpet is not in the budget." He further stated there was "no extra money for this kind of work." The owner stated the carpet in room 102 was scheduled to be replaced sometime this spring or summer and said, "We just need to get enough money together."<br><br>Urine odor:<br>During an observation on 4/19/16, at 1:10 p.m., the main floor bathroom behind the nurse desk had a strong urine odor present that permeated out into the hallway near the dining room. There was a soiled brief present in the bathroom garbage can. During a subsequent observation at 4:10 p.m., Urine odor was present upon entrance to the front door of the building. The soiled brief was still in the garbage can.<br><br>During an observation on 4/20/16, at 7:25 a.m., the following was identified. The hallway outside the main floor bathroom again had a strong urine | F 465   | A deep cleaning schedule has been developed with the housekeeper and will be monitored by the DON and Administrator. A Housekeeping Policy and updated cleaning schedule are located in Attachments C and D. A cleaning policy for the Kitchen and worksheets are provided in Attachments E, f and G and will be monitored by the Administator and Director of Nursing.<br><br>In the event additional resources are required to maintain this schedule, the owners of Southside have made the commitment to provide whatever resources are required to maintain a sanitary and safe environment. The ceramic floor in the kitchen is scheduled to be repaired on Sunday, May 29, 2016. |
|   |  |   | Ongoing<br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br>5/29/16  |

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |   |
| F 465  | <p>Continued From page 10</p> <p>odor. In the garbage can was a pair of women's underpants. At 8:35 a.m. the main floor bathroom near the entrance to the facility had a dark red substance that looked like blood splattered on the toilet seat and toilet lid.</p> <p>A review of the facility 's Resident Council Minutes dated 3/24/16, indicated an unidentified resident expressed concerns about the upstairs bathroom and stated, "it is always dirty." The minutes further indicated R15 voiced concerns regarding the downstairs bathrooms and indicated they were not clean. The notes indicated "perhaps [Housekeeper (HK)-A] and myself (recreational therapist) will try to come up with a solution to solve this problem." However, there was no evidence of follow-up to the concern.</p> <p>During an interview on 4/20/16, at 7:51 a.m., R15 stated there were no cleaning staff in the facility on the weekends. She stated the bathrooms "get stinky," and she had asked for wipes to clean the toilet but none had been provided.</p> <p>A review of the facility's Cleaning Schedule directed HK-A to clean doors, knobs, night stands, window sills, light fixtures, pipes, soiled walls and sprinkler pipe dust. The schedule for April 2016 was signed daily by HK-A. There was no evidence of a schedule to address areas that required deep cleaning.</p> <p>A facility policy regarding deep cleaning were request but none provided.</p> <p>Kitchen flooring:<br/>During tour on 4/20/16, at 1:58 p.m. the following sanitation concerns were observed and confirmed by Cook (C)-A.</p> | F 465   |   |                      |   |

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

PRINTED: 05/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>24E507</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>04/21/2016</b> |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SOUTHSIDE CARE CENTER</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2644 ALDRICH AVENUE SOUTH<br/>MINNEAPOLIS, MN 55408</b>             |                      |   |
| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |   |
| F 465  | Continued From page 11<br><br>The ceramic kitchen tile floor consisted of approximately eight by eight inch ceramic tiles. The surrounding grout around each tile in the walking area of the kitchen was black in color. The tiles in the corners of the kitchen and all wall edges had a heavy black residue buildup. There were a total of 12 tiles (three tiles in front of the sink, four in front of the refrigerator, five in front of the stove) that were cracked and/or chipped giving an uneven walking surface and black buildup in the cracks/chipped areas of the tiles.<br><br>During an interview on 4/20/16, at 1:58 p.m. the C-A verified the floor needed deep cleaning and was not aware of any deep cleaning policy. C-A stated that while he mops the floors daily, "I don't know who is responsible, I wouldn't have time to deep clean."<br><br>During an interview on 4/21/16, at 10:02 a.m. administrator (A) verified the floor needed to be repaired and grout cleaned. A stated the owner has made a commitment for any repairs.<br><br>Review of the Weekly Kitchen Cleaning Schedule dated 3/1/16 - 4/14/16 indicated the cupboards, drawers, dishwasher, light fixtures, stove vent hood, stove grates, upper refrigerator, storeroom refrigerator, storeroom shelves and floor, walls and coffee maker were to be cleaned weekly. The cleaning schedule lacked direction for any deep cleaning of the kitchen.<br><br>A deep cleaning policy was requested but not provided. | F 465   |   |                      |   |
| F 466<br>SS=C  | 483.70(h)(1) PROCEDURES TO ENSURE WATER AVAILABILITY   | F 466   |   |                      |   |



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SOUTHSIDE CARE CENTER</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2644 ALDRICH AVENUE SOUTH<br/>MINNEAPOLIS, MN 55408</b>   |                      |   |
| (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 466  | <p>Continued From page 12</p> <p>The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on interview and document review, the facility did not ensure an emergency water supply in the event of an outage. This had the potential to affect all 16 residents residing in the facility.</p> <p>Findings include:</p> <p>A facility policy undated Southside Care Center Emergency Water Supply Procedures (Interruption of Water Supply) undated, indicated "if normal water supply is interrupted, alternate sources include our own on-site well, bottled water, and possibly inter-connections via the city of Minneapolis. The policy did not identify a contracted service to provide drinking water, and indicated the facility would have to "call the Director of Water Works" to determine if the city had water supplies available for use. The policy indicated two liters of drinking water per person per day should be available at minimum. The policy did not identify a method for non-potable water usage.</p> <p>During an interview on 4/21/16, at 10:02 a.m. The administrator stated the facility did not have a contract to secure emergency water supplies. He further stated he contacted the owner who was not aware of a contract.</p> | F 466   | <p><b>F 466 - Emergency Water Procedures:</b></p> <p>The Policy for the provision of Emergency water is provided in Attachment H. Attachment I is a letter from Premium Waters, 720 29th Ave SE, Minneapolis, MN 55414 to provide emergency water supplies to Soutside in the event of a problem with the water supply.</p> | 5/12/16              |   |

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

May 18<sup>th</sup>, 2016

TO: Gloria Derfus, Unit Supervisor  
Minnesota Department of Health  
Health Regulation Division

From: Stephen Musser, Administrator

RE: Plan of Correction – F458

Southside Care Center is requesting a waiver for MN. Rule 4660.1430, sub.2. Built in closets were added to provide a larger, more adequate storage space for each resident. These closets have changed the usable square floor area to less than the required 80 square feet. An on-going assessment procedure is used whenever a new resident moves into a room to ensure they have adequate space for storage of their personal belongings. As noted in the survey results, residents who responded to interviews indicated that they “denied concerns with room size stating that she liked her area and there was no problem with the size of her room”. In another interview, resident “denied and concerns with room size or accommodations”.

The Administrator and Program Manager/Director of Nursing will monitor.

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

May 18<sup>th</sup>, 2016

TO: Gloria Derfus, Unit Supervisor  
Minnesota Department of Health  
Health Regulation Division

From: Stephen Musser, Administrator

RE: Plan of Correction – F354 – Staffing Waiver Request for full time registered nurse coverage for 8 hours/7 days a week coverage.

Southside Care Center has employed an Registered Nurse as the Director of Nursing and Program Manager/Charge Nurse five days/week for 8 hours/day. Southside has for many years had a waiver granted for this requirement and only during the most recent survey were they advised that Minnesota no longer has the option to request a waiver. As a result, Southside has begun a recruitment effort to hire a part time Register Nurse to cover 8 hours on Saturday and Sunday. In the interim, the current DON has been available on call or worked a weekend shift when required to fill in. Advertisements have been placed in Beyond.com and Indeed.com to fill this vacancy. The goal will be to fill these shifts within 30 days. However, Southside has previously been recruiting for additional LPN staffing on weekends offering competitive wages with no success and believe it is highly likely the recruitment for an RN for weekends only would be extremely difficult.

Therefore and as an interim measure, Southside Care Center requests a partial waiver from this requirement for weekend coverage. One shift (8 hours) on Saturday and Sunday would be staffed by a Licensed Practical Nurse. Southside is a Board and Care facility where each resident is ambulatory. Currently, an LPN is scheduled for one shift on each weekend day with on call availability by the DON. All residents at Southside are ambulatory and capable of self-preservation. Not have serious health problems that would require a skilled nursing facility. Annually each resident's physician provides a statement supporting this on file in the resident's record.

We appreciate your consideration of this request. Please contact me if you have any questions at 612-872-4233 or [sjmjim@msn.com](mailto:sjmjim@msn.com).

# Southside Care Center

Attachment C

## Housekeeping Policy

|   |                                    |
|---|------------------------------------|
| <b>Policy Area:</b> Environment   | <b>Subject:</b> Housekeeping       |
| <b>Title of Policy:</b> Routine and Deep Cleaning Policy  |                                    |
| <b>Effective Date:</b> May 17, 2016   |                                    |
| <b>Approved Date:</b> May 17, 2016<br><b>Revision Date:</b>   | <b>Approved by:</b> Stephen Musser |
| <p><b>1. Rationale or background to policy:</b><br/>Southside Care Center is committed to an environmentally clean environment. This policy is meant to outline daily, weekly and monthly routine and deep cleaning schedules (attached) but cleaning not limited to the schedule and to hold staff accountable to Southside's commitment. In addition, preventative maintenance and maintenance required will be a part of this policy.</p> <p><b>2. Policy Statement:</b> Southside Care Center is dedicated to providing a safe and clean environment for staff and residents.</p> <p><b>3. Procedures:</b></p> <ol style="list-style-type: none"><li>1. Housekeeping will perform all of the duties indicated on the daily schedule</li><li>2. Weekly duties will be split up within the week to ensure that all activities are completed</li><li>3. Monthly duties must also be included during the workday.</li></ol> |                                    |





# Southside Care Center

ATTACHMENT E

## Kitchen Cleaning Policy

|   |                                    |
|---|------------------------------------|
| <b>Policy Area:</b> Environment   | <b>Subject:</b> Kitchen Cleaning   |
| <b>Title of Policy:</b> Cleaning Policy   |                                    |
| <b>Effective Date:</b> 5/17/16  |                                    |
| <b>Approved Date:</b> 5/17/16<br><b>Revision Date:</b>  | <b>Approved by:</b> Stephen Musser |
| <p><b>1. Rationale or background to policy:</b><br/>Southside Care Center is committed to an environmentally clean environment. This policy is meant to outline daily, weekly and monthly cleaning schedules (attached) but cleaning not limited to the schedule and to hold staff accountable to Southside's commitment to sanitary conditions. In addition, preventative maintenance will be addressed.</p> <p><b>2. Policy Statement:</b> Southside Care Center is dedicated to providing a safe and clean environment for staff and residents.</p> <p><b>3. Procedures:</b> The cook on duty will do kitchen daily cleaning-See Attachment.<br/><b>Weekly Cleaning Schedule:</b> Cook 1 and Cook 2 will split the duties as indicated on schedule</p> |                                    |









**Southside Care Center  
2644 Aldrich Ave So.  
Minneapolis, MN 55408**

**Emergency Water Supply Procedures (Interruption of Water Supply)**

If the normal water supply for Southside Care Center is interrupted, alternate sources of water would be used to provide potable water for the residents and staff until water service is resumed.

Drinking water up to 10 gallons/day will be supplied by an agreement with Premium Waters, Inc (See attached). Additional water will be requested if needed, or obtained from local grocery/convenience stores.

Other measures will be take which will include:

1. All unnecessary functions requiring water usage will be postponed until further notice.
2. Disposable products will be obtained in the nutritional, nursing and laundry/housekeeping departments as applicable (i.e. dishes, cooking utensils, disposable diapers, paper towels, disposable wipes, and/or other required items)
3. Menus will be evaluated and changes as necessary by the Program Director.
4. Laundry services will be evaluated and changed as determined by the Administrator or Program Manager. Contracted laundry services may be utilized.
5. The Director of Nursing will evaluate the immediate needs of residents and prioritize required services.
6. Hand washing must be available even if tap water supplies are disrupted such as alcohol based gel products which would be made available.
7. Use of gloves is consistent with normal infection control practices.
8. Personal care of residents can be done with wet-wipes/baby wioes followed by use of alcohol based gel products.

Dated: May 2016

Southside Care Center  
2644 Aldrich Avenue So.  
Minneapolis, MN 55408  
612-872-4233

May 12, 2016

Dear Stephen Musser,

**Premium Waters Inc will supply your business with reasonable needs of portable water for emergency water supply. In the event that a problem occurs with your water supply, Premium Waters would be able to supply water as needed for up to 10 gallons per resident per day, Monday – Friday 6:00 am to 5:00 pm. We are closed on Saturdays and Sundays. If you would need a delivery Saturday or Sunday please contact me directly at my cell # below.**

**This supply would be at list price less the published discounts for volume purchases, pricing effective through 12.31.2016.**

Sincerely,

**Brad Wester – General Manager**

**Minneapolis Home and Office**

**Business hours 8:00 – 4:00 pm Monday – Friday.**

**Brad Wester 612-379-3519. After hours Brad**

**720 29<sup>th</sup> Avenue SE Suite "B" Minneapolis, MN 55414**

**Phone: 612.379-4141 Fax: 612.379-3543**

User ID:  
GVMG 185417 182708

Password:  
16260 182611

Entries must be completed within 14 days of purchase. Entrants must be 18 or older to enter. See complete rules on website. No purchase necessary.



**More saving.  
More doing.<sup>SM</sup>**

5800 CEDAR LAKE ROAD  
ST. LOUIS PARK, MN 55416 (952)512-0109

2806 00097 91161 05/10/16 11:35 AM  
CASHIER - SPOS01

ORDER ID: H2806-9422  
RECALL AMOUNT 4353.15

-----Tiered Credit Mail Offer-----  
Credit 24 Month Tiered Mail

|                          |            |            |
|--------------------------|------------|------------|
|                          | SUBTOTAL   | 4,353.15   |
|                          | SALES TAX  | 0.00       |
|                          | TOTAL      | \$4,353.15 |
| XXXXXXXXXXXX1997         | HOME DEPOT | 4,353.15   |
| AUTH CODE 010100/8974784 |            | TA         |
| CREDIT PROMOTION         | 20886 380  |            |



2806 97 91161 05/10/2016 2813

THE HOME DEPOT RESERVES THE RIGHT TO LIMIT / DENY RETURNS. PLEASE SEE THE RETURN POLICY SIGN IN STORES FOR DETAILS.

BUY ONLINE PICK-UP IN STORE  
AVAILABLE NOW ON HOMEDEPOT.COM.  
CONVENIENT, EASY AND MOST ORDERS  
READY IN LESS THAN 2 HOURS!

\*\*\*\*\*

**ENTER FOR A CHANCE  
TO WIN A \$5,000  
HOME DEPOT GIFT CARD!**

Tell us about your store visit!  
Complete our short survey and  
enter for a chance to win at:

[www.homedepot.com/survey](http://www.homedepot.com/survey)

**PARTICIPE EN UNA  
OPORTUNIDAD DE GANAR  
UNA TARJETA DE  
REGALO DE THD  
DE \$5,000!**

Comparta Su Opinion! Complete la breve encuesta sobre su visita a la tienda y tenga la oportunidad de ganar en:

[www.homedepot.com/survey](http://www.homedepot.com/survey)





# Proposal

Crew 2  
 2650 Minnehaha Ave.  
 Minneapolis, Mn 55406  
 Phone: 612-276-1642  
 Fax: 612-276-1742

## Authorized Service Provider

DATE: 5/5/16

|   |  |                             |  |
|---|--|-----------------------------|--|
| PROPOSAL SUBMITTED TO:<br>Southside Care Center     |  | Phone:<br>612-220-5568      |  |
| STREET:<br>2644 Aldrich Ave S                       |  | Attention:<br>Alan Kronfeld |  |
| CITY, STATE & ZIP CODE:<br>Minneapolis, MN          |  | Job<br>Location:            |  |
| Project Consultant:<br>Ben Pischke<br>Sales Manager |  | Cell<br>PHONE: 651-248-1176 |  |

| QUANTITY           | UNITS | DESCRIPTION  | TOTAL              |
|--------------------|-------|--|--------------------|
| <b>LABOR</b>       |       |  |                    |
| 46                 | yds   | Install carpet on steps & upper level landing.                   | \$ 328.44          |
| 80                 | yds   | Remove & dispose existing carpet                                 | 274.40             |
| 27                 | ea    | Step installation  | 154.17             |
| 122                | LF    | Remove & dispose existing wood base.                             | 174.46             |
| 130                | LF    | Install new vinyl base in the patient room & upper level landing | 167.70             |
|                    |       |  | -                  |
| 305                | sq ft | Install LVP flooring in patient room                             | 652.70             |
| 2                  | Ea    | Floor prep   | 205.72             |
| 305                | sq ft | Install new 1/4" underlayment                                    | 414.80             |
| 3                  | LF    | Install transition from new LVP to existing vinyl                | 6.42               |
|                    |       |  | -                  |
| 1                  | Ea    | Furniture moving in patient room                                 | 214.29             |
|                    |       |  | -                  |
|                    |       |  | -                  |
|                    |       | **Labor bid at weekday / daytime hours.                          | -                  |
|                    |       | **Tentative start date 3 weeks after purchase.                   | -                  |
|                    |       |  | -                  |
|                    |       |  | -                  |
|                    |       |  | -                  |
|                    |       |  | -                  |
|                    |       |  | -                  |
|                    |       |  | -                  |
|                    |       |  | -                  |
|                    |       |  | -                  |
|                    |       |  | -                  |
|                    |       |  | -                  |
|                    |       |  | -                  |
|                    |       |  | -                  |
|                    |       |  | -                  |
| <b>LABOR TOTAL</b> |       |  | <b>\$ 2,593.10</b> |

**GRAND TOTAL \$ 4,353.15**

**Acceptance of Proposal** — The above prices, specifications and conditions are satisfactory and are hereby accepted. You are authorized to do the work as specified. Payment will be made as outlined above. **Concealed damages and/or items not specifically listed an quoted above are strictly excluded from this estimate.**

Signature:

Signature:

Date of acceptance:



# Proposal

Crew 2  
2650 Minnehaha Ave.  
Minneapolis, Mn 55406  
Phone: 612-276-1642  
Fax: 612-276-1742

## Authorized Service Provider

DATE: 5/5/16

|   |                             |
|---|-----------------------------|
| PROPOSAL SUBMITTED TO:<br>Southside Care Center     | Phone:<br>612-220-5568      |
| STREET:<br>2644 Aldrich Ave S                       | Attention:<br>Alan Kronfeld |
| CITY, STATE & ZIP CODE:<br>Minneapolis, MN          | Job<br>Location:            |
| Project Consultant:<br>Ben Pischke<br>Sales Manager | Cell<br>PHONE: 651-248-1176 |

**WE PROPOSE** Hereby to furnish material and labor complete in accordance with specifications below, for the sum of:

|  |                               |
|--|-------------------------------|
|  | DOLLARS<br><b>\$ 4,353.15</b> |
|--|-------------------------------|

All material is guaranteed to be as specified. All work to be completed in a workmanlike manner according to standard practices. Any alteration or deviation for specifications below involving extra costs will be executed only upon written orders, and will become an extra charge over and above the estimate. All agreements contingent upon strikes, accidents or delays beyond our control. Owner to carry fire, tornado and other necessary insurance. Our workers are fully covered by Workmen's Compensation Insurance.

Authorized  
Signature

NOTE: This proposal may be withdrawn by us  
if not accepted withi 30DAYS

We hereby submit specifications and estimates for:

| QUANTITY              | UNITS | DESCRIPTION  | PRICE              |
|-----------------------|-------|--|--------------------|
| <b>MATERIAL</b>       |       |  |                    |
| 46                    | yds   | Absolute 20oz - Color: Rock Opera broadloom carpet       | \$ 561.20          |
| 1                     | Ea    | Commercial pad for steps                                 | 98.54              |
| 130                   | LF    | Johnsonite 4" tall vinyl base                            | 100.10             |
| 1                     | ea    | Iloc adhesive for upper level landing                    | 49.27              |
|                       |       |  | -                  |
| 360                   | sq ft | Graniac 12 mil LVP for patient room. Color: Carmello 332 | 720.00             |
| 1                     | Ea    | Mohawk Drop Charge                                       | 101.00             |
| 1                     | Ea    | Transition from new LVP to existing vinyl                | 15.40              |
| 2                     | Ea    | Mohawk M950 LVP Adhesive - 1 gal                         | 114.54             |
|                       |       |  | -                  |
|                       |       |  | -                  |
|                       |       |  | -                  |
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|                       |       |  | -                  |
|                       |       |  | -                  |
|                       |       |  | -                  |
|                       |       |  | -                  |
| <b>MATERIAL TOTAL</b> |       |  | <b>\$ 1,760.05</b> |



April 4, 2016

Southside Care Center  
2644 Aldrich Ave So.  
Minneapolis, MN 55408  
512-872-4233

Dear Relatives and Friends,

Southside Care Center is once again pursuing the possibility of starting a Family Council. The purpose of the council will be to promote communication dealing with the care and support the residents residing here.

Southside Care Center is required by the Minnesota department of Health to contact relatives and significant others to see if there is sufficient interest in setting up this Council. If there is interest in beginning to meet as a group, I will contact those persons who have expressed an interest to set a time a date for a meeting. Please return this letter in the self-addressed envelope with your response below indicating your interest or no interest as soon as possible.

Thank you for your time and consideration.

Sincerely,



Robert Shivcharran  
Activity Director

Yes, I am interested in participating in a family Council

No, I am not interested

---

(Your Name)

Southside Care Center  
2644 Aldrich Ave So  
Minneapolis, MN 55408

May 19, 2016

Gloria Derfus, Unit Supervisor  
Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64900  
St Paul, MN 55164-0970

RE: Southside Care Center – Project Number SE507025

Dear Ms. Derfus,

Please find the Plans of Correction and attachments for Southside Care Center. Please do not hesitate to contact me at 612-872-4233/612-220-5568 or [sjmjim@msn.com](mailto:sjmjim@msn.com) if you have any questions or concerns.

Sincerely,

A handwritten signature in black ink that reads "Stephen Musser". The signature is written in a cursive style with a large, stylized initial "S".

Stephen Musser  
Administrator

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

*FES07024*

PRINTED: 05/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |   |   |   |
|--|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>SOUTHSIDE CARE CENTER</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2644 ALDRICH AVENUE SOUTH<br/>MINNEAPOLIS, MN 55408</b>             |   |
| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE                                |
| K 000  | <p><b>INITIAL COMMENTS</b></p> <p><b>FIRE SAFETY</b></p> <p>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.</p> <p>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.</p> <p>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on April 21, 2016. At the time of this survey, Southside Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO:</p> <p>Healthcare Fire Inspections<br/>State Fire Marshal Division<br/>445 Minnesota St., Suite 145<br/>St. Paul, MN 55101-5145, OR</p> | K 000   | <p><b>APPROVED</b> <i>Tom Linhoff</i><br/><b>By Tom Linhoff at 12:55 pm, Jul 20, 2016</b></p>                   |   |

LABORATORY DIRECTOR'S OR FURNISHER'S REPRESENTATIVE'S SIGNATURE

*Stephen Mussen*

TITLE

Administrator

(X6) DATE

5/19/16

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



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

PRINTED: 05/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>24E507</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br><br>B. WING _____   |                         | (X3) DATE SURVEY COMPLETED<br><br><b>04/21/2016</b> |
|--|---|---|---|-------------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SOUTHSIDE CARE CENTER</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2644 ALDRICH AVENUE SOUTH<br/>MINNEAPOLIS, MN 55408</b>   |                         |   |
| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   | (X5) COMPLETION DATE    |   |
| K 000  | Continued From page 1<br>By email to:<br>Marian.Whitney@state.mn.us and<br>Angela.Kappenman@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br><br>Southside Care Center is a 2-story building with a full basement. The building was constructed 1909 and was determined to be of Type V(000) construction. This building is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 17 beds and had a census of 16 at the time of the survey. | K 000   |   |                         |   |
| K 012<br>SS=F  | The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:<br>NFPA 101 LIFE SAFETY CODE STANDARD<br>Building construction type and height meets one of the following:<br>19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1<br>This STANDARD is not met as evidenced by:<br>Based on observation, this building does not meet the requirement for construction type and   | K 012   | K012 - 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 | 7/13/16<br>See<br>Attch |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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| K 012  | Continued From page 2<br>height.<br>This deficient practice could affect all residents.<br><br>Findings include:<br><br>On facility tour between 9:00 AM and 12:00 PM on April 21, 2016, observation revealed that the building construction is Type V (000), which is does not meet the requirement for a 2-story building.<br><br>This deficient practice was verified by the Administrator at the time of the inspection.<br><br>Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.   | K 012   |  |   |
| K 033<br>SS=F  | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Exit enclosures (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 7.1.3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1<br>This STANDARD is not met as evidenced by:<br>Based on observation, the stairway enclosure of this facility does not meet the required one (1) hour fire resistive construction. This deficient practice could affect all residents.<br><br>Findings include:<br><br>On facility tour between 9:00 AM and 12:00 PM on April 21, 2016, observation revealed that the wall of the stair enclosures are constructed of plaster on wood lath on wood studs, which does | K 033   | K033 - 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. | 7/13/16<br>see<br>attach                            |

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| K 033  | Continued From page 3<br>not meet minimum the requirements for this type of facility.<br><br>This deficient practice was verified by the Administrator at the time of the inspection.<br><br>Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.   | K 033   |  |   |
| K 034<br>SS=F  | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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<br>This STANDARD is not met as evidenced by:<br>Based on observation, the facility failed to maintain the stairwells in accordance with LSC (2000) Chapter 7.2. This deficient practice could affect all residents.<br><br>Findings include:<br><br>On facility tour between 9:00 AM and 12:00 PM on April 21, 2016, observation revealed that the back stairs at the rear exit are only 32" wide.<br><br>This deficient practice was verified by the Administrator at the time of the inspection.<br><br>Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code. | K 034   | K034 - 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. | 7/13/16<br>Sec<br>attach.                           |
| K 039<br>SS=F  | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4   | K 039   |  |   |

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| K 039  | Continued From page 4<br>feet. 19.2.3.3<br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the second floor corridor does not meet the minimum 48" width requirement. This deficient practice could affect all residents.<br><br>Findings include:<br>During a tour of the facility between 9:00 AM and 12:00 PM on April 21, 2016, observation revealed that the first floor corridor is only 33 inches in clear width and not the 48 inches required for this type of facility.<br><br>This deficient practice was verified by the Administrator at the time of the inspection.<br><br>Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code. | K 039   | <b>K039 - 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.</b> | 7/13/16<br>See<br>Attch                             |

# **REPORT OF CONSULTANT FSES FINDINGS**

**Southside Care Center  
2644 Aldrich Avenue South  
Minneapolis, MN 55408**

**Provider No. 24E507**

**Date of Survey: July 13, 2016**

Prepared by:  
Robert L. Imholte, President  
*Fire Safety Resources, LLC*  
16768 County Road 160  
Cold Spring, MN 56320  
320-685-8559  
[RimholteFiresafe@aol.com](mailto:RimholteFiresafe@aol.com)

July 14, 2016

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

**RE: FSES at Southside Care Center**

Dear Mr. Musser:

Enclosed please find the survey information relating to the fire safety evaluation of Southside Care Center, 2644 Aldrich Avenue South in Minneapolis conducted on 07/13/2016. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(01), *Guide to Alternative Approaches to Life Safety*.

The FSES is a rating system designed to evaluate the level of fire/life safety in health care facilities and serves as a method to demonstrate alternative compliance with the 2000 edition of the *Life Safety Code*® (NFPA 101). An FSES was made necessary in this case because of deficiencies cited against the facility during a state fire/life safety recertification survey conducted on 04/21/2016 and a Life Safety Code Comparative Federal Monitoring Survey conducted on 05/02/2016 relating to:

- K012 – Construction type and height;
- K033 – Exit stairway enclosure construction;
- K034 – Exit stairway width;
- K038 – Headroom clearance, door width, door swing, egress through intervening room and stair riser height; and
- K039 – First Floor corridor width.

The following factors served as the basis for this evaluation:

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

Based on the conditions found during the 07/13/2016 FSES evaluation, all four parameters in Table 7 of the FSES worksheets, ZONE FIRE SAFETY EQUIVALENCY EVALUATION, in all three zones evaluated were found to have a score of zero or greater. *Fire Safety Resources* finds, therefore, that Southside Care Center has achieved a passing FSES score.

Mr. Stephen Musser  
FSES: Southside Care Center  
July 14, 2016  
Page 2 of 2

Should you have any questions or need additional information, please don't hesitate to get back to me.

Wishing you a safe day!

A handwritten signature in cursive script that reads "Robert L. Imholte". The signature is written in black ink and includes a long, sweeping horizontal stroke at the end.

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

Enclosures

RLI/rli

## FIRE SAFETY EVALUATION

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

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

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What follows is a report on the results of a fire safety evaluation of the above-named facility that was conducted during an on-site visit to the facility between 0905 hours and 1055 hours on 07/13/2016. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(01), *Guide to Alternative Approaches to Life Safety*. Based on this evaluation, Southside Care Center has achieved a passing score on the FSES.

In addition to the 07/13/2016 on-site visit, the findings outlined herein are based on:

- Information provided by Mr. Stephen Musser, Administrator, and Ms. Germaine Mouelle, Program Manager/DON; and
- A review of the Statements of Deficiencies (Form CMS-2567) from a state fire/life safety recertification survey conducted on 04/21/2016 and a Life Safety Code Comparative Federal Monitoring Survey conducted on 05/02/2016.

### **Initial Comments:**

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

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

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

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

The facility has a manual fire alarm system, which is monitored for automatic fire department notification. As noted later in this report, there are system-connected automatic smoke detectors on all three levels of the building and battery-operated single station smoke alarms in the resident sleeping rooms. Based on interview of the Administrator and documentation review, it was found that the following fire alarm system deficiencies observed during the 05/02/2016 Federal Monitoring Survey and cited under data tags K052 and K054 have been corrected as follows:



- Nardini Fire Equipment Company has provided the facility with a 5-page test and inspection report that appears to be based on Figure 7.8.2 from the 2013 edition of NFPA 72 that includes a list of the initiating devices tested and the results of the test (see data tag K052).
- Documentation was provided confirming that the smoke detectors connected to the building fire alarm system were sensitivity tested by Nardini Fire Equipment Company on 05/12/2016 (see data tag K054).

The building is protected throughout by a supervised, wet-pipe automatic fire sprinkler system consisting of quick-response sprinklers. Based on interview of the Administrator and documentation review, it was found that the following sprinkler system deficiencies observed during the 05/02/2016 Federal Monitoring Survey and cited under data tags K056 and K062 have been corrected as follows:

- Automatic fire sprinkler protection has been added to the enclosed 51" x 44" vestibule at the west (rear) exit (see data tag K056).
- The facility has engaged Viking Automatic Sprinkler Company to conduct quarterly waterflow testing of the building fire sprinkler system (see data tag K062). The first test was conducted on 06/23/2016.

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

#### **All Levels – TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET**

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

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

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

***Surveyor Note #1:*** A review of the Statement of Deficiencies from the 05/02/2016 Federal Monitoring Survey revealed that an electrical (K147) deficiency was issued because a 3 to 1 electrical adaptor was found in use in the corridor by the nurses station on 1<sup>st</sup> Floor. Based on observation and interview of the Administrator, it was confirmed during this FSES survey that the adaptor has been removed and replaced with a listed relocatable power tap plugged directly into an approved electrical outlet.

**Surveyor Note #2:** Given the small area of the kitchen coupled with the small size of the kitchen hood (approximately 25" x 34" in dimension), it is the opinion of Fire Safety Resources, LLC, that the sidewall spray sprinkler protection in the room provides adequate protection for the kitchen cooking equipment as allowed by NFPA 101(00), Sec. 9.2.3 for existing installations. That said, however, the facility has decided to have automatic fire sprinkler protection installed in the kitchen hood by 07/29/2016 to address data tag K069, Item 1 cited during the 05/02/2016 Federal Monitoring Survey.

- No space heaters or incinerator were found.
- The facility's evacuation plan and fire drill records were reviewed and appeared to be in order.

**Surveyor Note:** A review of the Statement of Deficiencies from the 05/02/2016 Federal Monitoring Survey revealed that the facility was cited for failure to document the transmission of the fire alarm signal during fire drills (see data tag K050). Based on record review and interview of the Program Manager/DON, it was confirmed that the facility's fire drills include the sounding of the building fire alarm system and confirmation of receipt of the fire alarm signal by the monitoring company, both of which are documented on the monthly fire drill reports.

- The facility's smoking regulations were reviewed and appeared to be in order. The facility restricts smoking to the outside patio area.
- Draperies, cubicle curtains, upholstered furniture, mattresses and decorations were found to be in accordance with NFPA 101(00), Sec. 19.7.5.

**Surveyor Note:** A review of the Statement of Deficiencies from the 05/02/2016 Federal Monitoring Survey revealed that the facility was cited because untreated fabric draperies were found in Room 205 on 2<sup>nd</sup> Floor (see data tag K074). Based on observation and interview of the Administrator, it was confirmed during this FSES survey that the untreated fabric draperies have been removed – no window curtains/draperies were found during this building tour. The facility has submitted a Plan of Correction indicating that residents and family members will be advised upon admission that all curtains a resident wishes to hang must be of a fire resistant material and, further, that the Administrator and Program Manager will conduct a weekly walk-through of the building to ensure that any noncompliant curtains found are removed. The weekly tours were found to be documented in a log.

- Portable fire extinguishers, EXIT signage and emergency lighting appeared to be provided and maintained in accordance with applicable requirements.

**Surveyor Note:** A review of the Statement of Deficiencies from the 05/02/2016 Federal Monitoring Survey revealed that the facility was cited because there was no K-type fire extinguisher in the kitchen on 1<sup>st</sup> Floor (see data tag K069, Item 2). Based on observation during this FSES survey, it was confirmed that the CO<sub>2</sub> extinguisher in the kitchen has been replaced with a new K-type fire extinguisher.

**Zone 1 – Basement Level:**

**TABLE 1. OCCUPANCY RISK PARAMETER FACTORS**

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

**TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES**

1. Construction [Score: -7]:  
Because of exposed wood joists found in the basement ceiling, the building was assigned a Type V(000) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:  
Interior finish in spaces that could be considered part of a corridor was plaster.
3. Interior Finish (Rooms) [Score: +3]:  
Interior finish in rooms was plaster; in some places gypsum wallboard has been added.
4. Corridor Partitions/Walls [Score: +1]:  
For purposes of this FSES, the basement level was treated as a single hazardous area consisting of multiple rooms. The wall separating the basement from the exitway was found to be constructed of plaster/gypsum wallboard on wood lath on both sides of wood studs, which likely provides a fire resistance of at least ½-hour.
5. Doors to Corridor [Score: +2]:  
The door at the bottom of the stairway leading from the basement was found to be a self-closing, 90-minute fire-rated door in a wood frame.
6. Zone Dimensions [Score: 0]:  
This score was assigned per instruction in Footnote *b* to this Table. The building measures approximately 70 feet in length on this level and Parameter 10 was assigned a score of -8. There is only one means of egress from this level. This results in a dead-end condition.
7. Vertical Openings [Score: 0]:  
A 90-minute fire-rated self-closing door in a wood frame was found at the bottom of the basement stairs. The walls of the stair enclosure into which the door opens are constructed of plaster on wood lath/gypsum wallboard on wood studs. These conditions likely do not provide the 1-hour fire resistance required by NFPA 101(00), Sec. 19.3.1.1.
8. Hazardous Areas [Score: 0]:  
Again, for purposes of this FSES, the basement level was treated as a single hazardous area consisting of multiple rooms. This level is sprinkler protected throughout as required by NFPA 101A(01), Sec. 4.6.8.2 and smoke-separated as required by NFPA 101(00), Sec. 19.3.2.1.
9. Smoke Control [Score: 0]:  
This score was assigned per Footnote *c* to this Table and the fact that residents are not allowed on this level.

10. Emergency Movement Routes [Score: -8]:

This score was assigned for the following reasons:

- There is only one way out of the basement, which does not meet the requirements of NFPA 101(00), Sec. 19.2.4.1.
- The path of travel is up a stairway that is enclosed with construction having less than 1-hour fire resistance as described in Item 7, Vertical Openings, above.
- Headroom clearance at the bottom of the basement stairway was found to be only 62 inches instead of the 80 inches required by NFPA 101(00), Sec. 7.1.5.
- The stairway from the basement was found to be only 30 inches in clear width instead of the 36 inches required by NFPA 101(00), Sec. 7.2.2.2.1(b) and Table 7.2.2.2.1(b).
- The stairway from the basement was found to have winder-type treads, which are not allowed by NFPA 101(00), Sec. 19.2.2.3.
- The door to the exterior from the west (rear) stair enclosure is only 30 inches in clear width.

11. Manual Fire Alarm [Score: +2]:

There is a manual fire alarm pull station along the path of travel from the basement. The building's fire alarm system is monitored by Wright-Hennepin (WH) Response.

12. Smoke Detection and Alarm [Score: +3]:

This score was assigned per instruction in NFPA 101A(01), Sec. 4.6.13.4.3 and Footnote *g* to this Table. The zone is protected with quick-response sprinklers. There is a system-connected smoke detector near the building's fire alarm control panel and another in the 'hallway' leading to the boiler room. Because this coverage is not included in any of the categories of NFPA 101A(01), Sections 4.6.12.2 through 4.6.12.5, this Parameter was scored as "None".

13. Automatic Sprinklers [Score: +10]:

The building is protected by a supervised, wet-pipe automatic fire sprinkler system consisting of quick-response sprinklers.

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**Zone 2 – First Floor:**

**TABLE 1. OCCUPANCY RISK PARAMETER FACTORS**

1. Resident Mobility (*M*) [Value assigned = 1.6]: This score was assigned to address the "worst-case scenario". It was reported that all residents housed in this zone are capable of removing themselves from danger exclusively by their own efforts. A review of the facility's Form CMS-672, dated 07/13/2016, revealed that all 17 residents are classified as "Independently ambulatory". One (1) resident, however, was found to be classified as "Ambulation with assistance or assistive device". Based on interview of the Administrator and Program Manager/DON, it was determined that this resident is housed on 1<sup>st</sup> Floor and occasionally uses a cane. A review of the facility's admission policy and interview of the Administrator and Program Manager/DON confirmed that the facility will only admit residents who are ambulatory and capable of going up and down stairs without assistance.
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to seven (7) residents in this zone. The zone also contains the facility living/dining room, which is available for use by all residents.
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 4.0]: There is one (1) staff person on duty on the night shift. Because this staff person leaves the floor to make rounds of the building every 2 hours, this Parameter was scored as "One or More over None".

5. Patient Average Age (A) [Value assigned = 1.2]: This score was assigned to address the “worst-case scenario”. Only one (1) of the residents currently housed in this zone is age 65 years and over. Four (4) other residents who use the living/dining room area are also age 65 years and over.

**TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES**

1. Construction [Score: -2]:  
Because of exposed wood joists found in the basement ceiling, the building was assigned a Type V(000) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:  
Interior finish was found to be plaster or gypsum wallboard or a combination thereof.
3. Interior Finish (Rooms) [Score: +3]:  
Interior finish was found to be plaster or gypsum wallboard or a combination thereof.
4. Corridor Partitions/Walls [Score: +1]:  
Corridor walls are constructed of ½-inch thick gypsum wallboard installed over plaster on wood lath on both sides of wood studs, which likely provides a fire resistance of at least ½-hour.
5. Doors to Corridor [Score: +1]:  
Corridor doors were found to be of 1-3/4-inch solid wood construction. The bathroom doors were found to be of hollow core wood construction, but pursuant to direction given in NFPA 101A(00), Sec. 4.6.5, these doors were not considered in classifying doors to corridors, as no flammable or combustible materials were found in the rooms.
6. Zone Dimensions [Score: 0]:  
This score was assigned per instruction in Footnote *b* to this Table. The building measures approximately 70 feet in length on this level and Parameter 10 was assigned a score of -8. There is only one complying means of egress out of this level, which creates a dead-end condition.
7. Vertical Openings [Score: 0]:  
While the self-closing door opening from the kitchen into the west (rear) stairway was found to be a 90-minute fire-rated assembly (including a metal frame), the stair enclosure walls are constructed of plaster on wood lath/gypsum wallboard on wood studs, which likely does not provide the 1-hour fire resistance required by NFPA 101(00), Sec. 19.3.1.1.
8. Hazardous Areas [Score: 0]:  
Hazardous areas were found to be sprinkler protected as required by NFPA 101A(01), Sec. 4.6.8.2 and smoke-separated as required by NFPA 101(00), Sec. 19.3.2.1.
9. Smoke Control [Score: 0]:  
This score was assigned per Footnote *c* to this Table (fewer than 31 residents).
10. Emergency Movement Routes [Score: -8]:  
While there are two ways out of this level, this score was assigned for the following reasons:
  - Access to the rear (west) exit passes through the kitchen, which does not meet the requirements of NFPA 101(00), Sec. 7.5.1.7;
  - From the kitchen, occupants must pass through a door that opens into the west (rear) stairway enclosure. The door swings against egress travel, which does not meet the requirements of NFPA 101(00), Sec. 7.2.1.4.3. In addition, the door to the exterior from this enclosure is only 30 inches in clear width;
  - The stairway from the 1<sup>st</sup> Floor landing to the west (rear) exit is only 25 inches in clear width and, therefore, could not be credited as an egress route [see NFPA 101A(01), Sec. 4.6.10.3.2];

10. Emergency Movement Routes (continued)

- While the east (front) corridor measures 43 inches in clear width, the west (back) corridor was found to narrow to 32 inches clear width because of the desk serving as the nurse station;
- The door to the west (rear) stairway measures only 29 inches in clear width and the resident room doors were found to be only 29.5 inches in clear width. While the door width meets the requirements of Exception No. 2 to NFPA 101(00), Sec. 19.2.3.5 (the facility's fire plan does not require evacuation by bed, gurney or wheelchair), NFPA 101A(01), Sec. 4.6.10.3.2 does not allow doors less than 32 inches in the clear to be credited as an egress route for purposes of the FSES; and
- There is a variance of over 1-inch in the height of adjacent risers in the middle of the steps outside the east (front) entrance, which does not meet the requirements of NFPA 101(00), Sec. 7.2.2.3.6.

11. Manual Fire Alarm [Score: +2]:

There are manual fire alarm pull stations at the front and back doors. The fire alarm system is monitored by Wright-Hennepin (WH) Response.

12. Smoke Detection and Alarm [Score: +3]:

This score was assigned per instruction in NFPA 101A(01), Sec. 4.6.13.4.3 and Footnote *g* to this Table. The zone is protected with quick-response sprinklers. System-connected smoke detectors were found in the Day Room/Dining Room area and in the corridors leading to the main entrance and to the kitchen. This was scored as "Corridor Only" smoke detection. Battery-operated single station smoke alarms were found in the resident sleeping rooms.

13. Automatic Sprinklers [Score: +10]:

The building is protected by a supervised, wet-pipe automatic fire sprinkler system consisting of quick-response sprinklers.

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**Zone 3 – Second Floor:**

**TABLE 1. OCCUPANCY RISK PARAMETER FACTORS**

1. Resident Mobility (*M*) [Value assigned = 1.0]: It was reported that all residents housed in this zone are capable of removing themselves from danger exclusively by their own efforts. A review of the facility's admission policy and current Form CMS-672, dated 07/13/2016, and interview of the Administrator and Program Manager/DON confirmed that the facility will only admit residents who are ambulatory and capable of going up and down stairs without assistance.
2. Patient Density (*D*) [Value assigned = 1.2]: There is bed capacity for up to ten (10) residents in this zone.
3. Zone Location (*L*) [Value assigned = 1.2]: This zone is one floor height above First Floor.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 4.0]: There is only one (1) staff person on duty on the night shift. This staff person is located on First Floor, but makes rounds of the building every 2 hours.
5. Patient Average Age (*A*) [Value assigned = 1.2]: This score was assigned to address the "worst-case scenario". Four (4) of the residents currently housed in this zone are age 65 years and over.

**TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES**

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

4. Corridor Partitions/Walls [Score: 0]:  
Corridor walls are constructed of ½-inch thick gypsum wallboard installed over plaster on wood lath on both sides of wood studs. Because it appears that the corridor walls do not extend to the underside of the roof above, they were graded as “< ½ hour” in accordance with NFPA 101A(01), Sec. 4.6.4.2.
5. Doors to Corridor [Score: +1]:  
Corridor doors were found to be of 1-3/4-inch solid wood construction. The door to the bathroom was found to be of hollow core wood construction, but pursuant to direction given in NFPA 101A(00), Sec. 4.6.5, this door was not considered in classifying doors to corridors, as no flammable or combustible materials were found in the room.
6. Zone Dimensions [Score: 0]:  
This score was assigned per instruction in Footnote *b* to this Table. The building measures approximately 70 feet in length on this level and Parameter 10 was assigned a score of -8. Due to the lack of complying means of egress out of this level, a dead-end condition is created.
7. Vertical Openings [Score: 0]:  
Twenty-minute-rated self-closing doors in steel frames were found at the top of the east (front) and west (rear) stairways. The walls of the stair enclosures are constructed of plaster on wood lath/gypsum wallboard on wood studs. These conditions do not provide the 1-hour fire resistance required by NFPA 101(00), Sec. 19.3.1.1.
8. Hazardous Areas [Score: 0]:  
No hazardous area deficiencies were found in this zone.
9. Smoke Control [Score: 0]:  
This score was assigned per Footnote *c* to this Table (fewer than 31 residents).
10. Emergency Movement Routes [Score: -8]:  
There are two ways out of this level. However, as indicated in Item 7, Vertical Openings, the stair enclosures serving this level currently provide protection of less than 1-hour fire resistance, which does not meet the requirements of NFPA 101(00), Sections 7.2.2.5.1 and 7.1.3.2. The following deficient conditions were also noted:
  - The east (front) stairway measures 36 inches in clear width. The west (rear) stairway is 36 inches in clear width, but narrows to 31 inches in clear width approximately half way down and further narrows to 25 inches in clear width below the landing on 1<sup>st</sup> Floor, and, therefore, could not be credited as an egress route [see NFPA 101A(01), Sec. 4.6.10.3.2];
  - The door to the exterior from the west (rear) stair enclosure is only 30 inches in clear width;
  - The door at the top of the east (front) stair enclosure, which used to swing over the stairs, was found to have been changed to swing into the corridor, which does not meet the requirements of NFPA 101(00), Sec. 7.2.1.4.3;
  - Headroom clearance at a point approximately two-thirds of the way down the east (front) stairway was found to be only 75 inches instead of the 80 inches required by NFPA 101(00), Sec. 7.1.5; and
  - Resident room doors were found to measure between 29 and 30 inches in clear width. While the door width meets the requirements of Exception No. 2 to NFPA 101(00), Sec. 19.2.3.5 (the facility’s fire plan does not require evacuation by bed, gurney or wheelchair), NFPA 101A(01), Sec. 4.6.10.3.2 does not allow doors less than 32 inches in the clear to be credited as an egress route for purposes of the FSES.
11. Manual Fire Alarm [Score: +2]:  
One manual fire alarm pull station was found at the door to the west (rear) stair. This appears to meet the intent of Exception No. 1 to NFPA 101(00), Sec. 19.3.4.2. The fire alarm system is monitored by Wright-Hennepin (WH) Response.

12. Smoke Detection and Alarm [Score: +3]:

This score was assigned per instruction in NFPA 101A(01), Sec. 4.6.13.4.3 and Footnote *g* to this Table. The zone is protected with quick-response sprinklers. A system-connected smoke detector was found in the corridor. Battery-operated single station smoke alarms were found in the resident sleeping rooms.

13. Automatic Sprinklers [Score: +10]:

The building is protected by a supervised, wet-pipe automatic fire sprinkler system consisting of quick-response sprinklers.

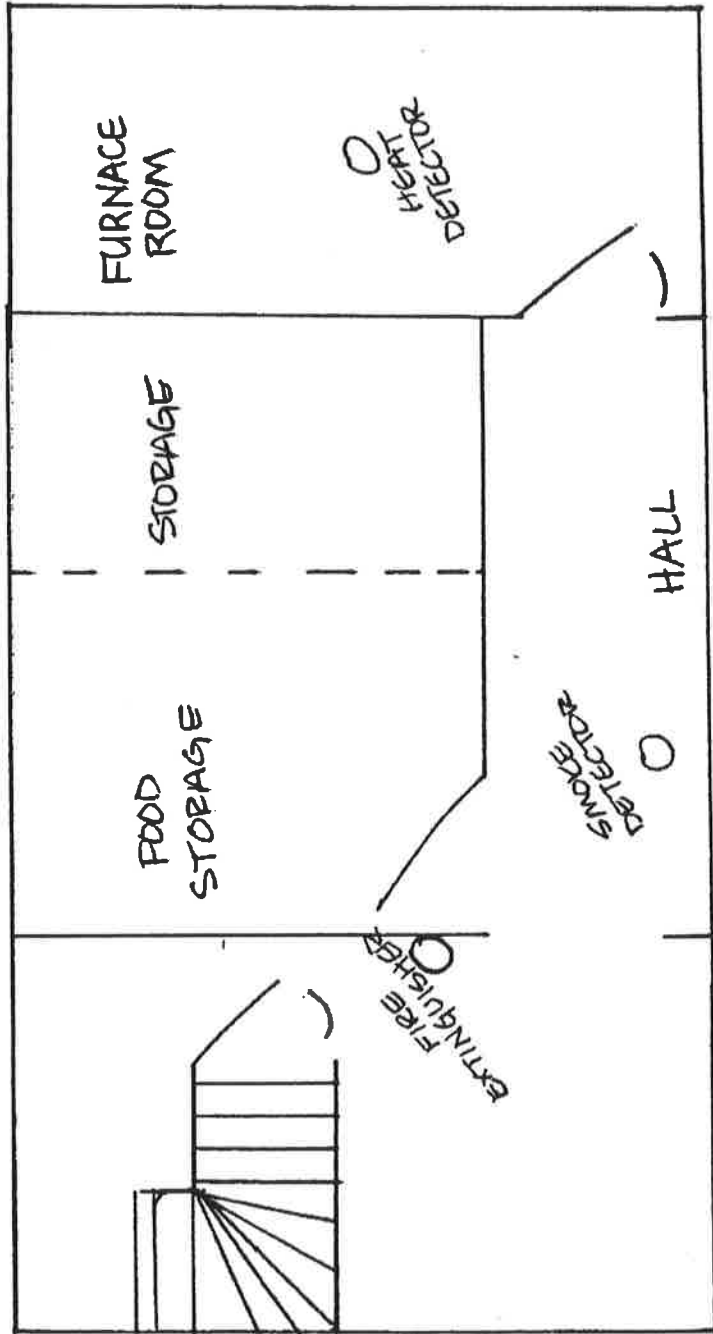
\* \* \* \* \*

It must be noted that the scores and values assigned to the parameters in the tables on the FSES worksheets were based on conditions found between between 0905 hours and 1055 hours on 07/13/2016. Any changes in those conditions after that date could affect the scores and values, either positively or negatively. Again, based on this evaluation, Southside Care Center **has** achieved a passing score on the FSES. No other assessment of the level of safety in this facility is either intended or implied by *Fire Safety Resources, LLC*.

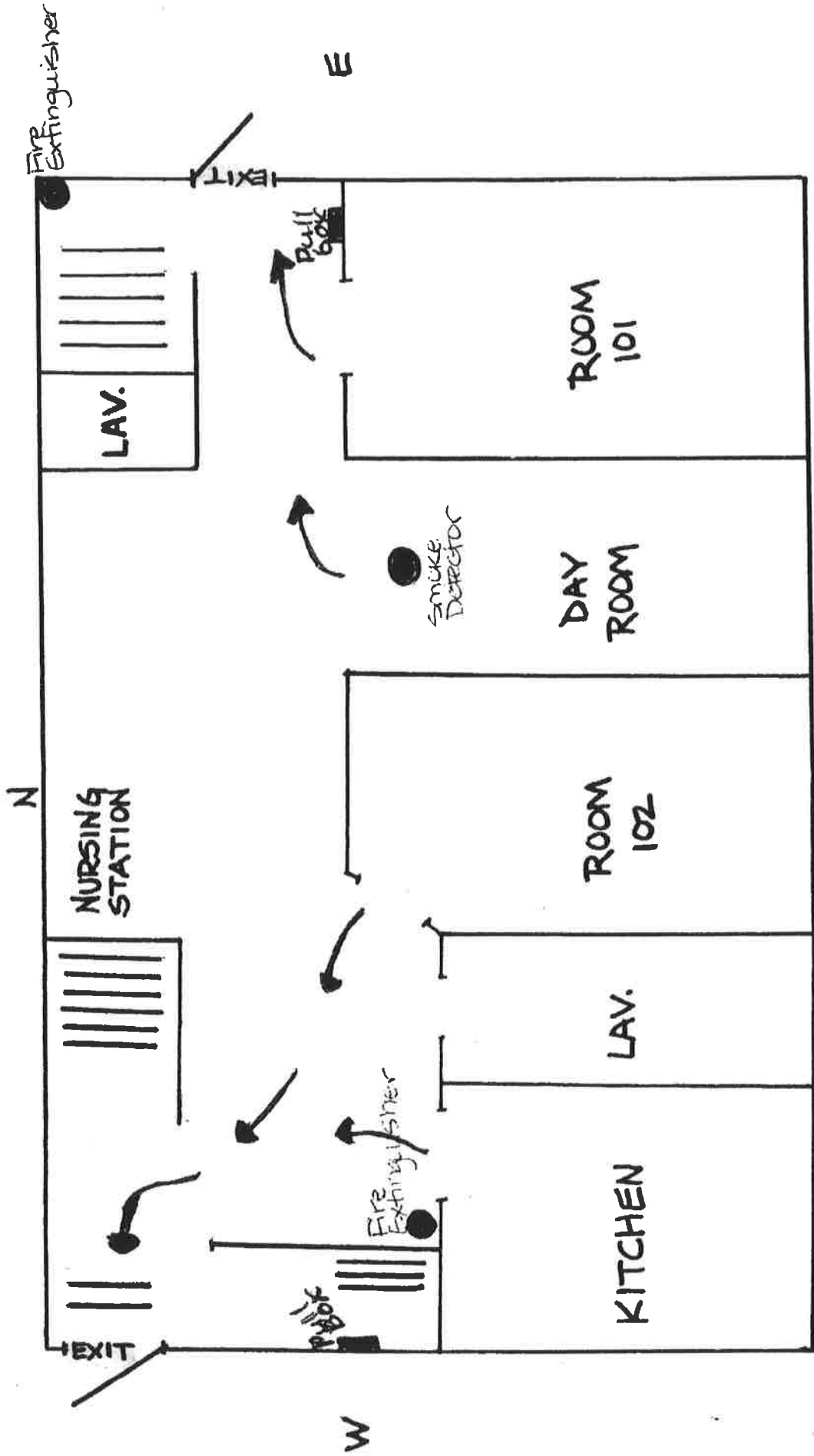


# SOUTHSIDE CARE CENTER

## BASEMENT

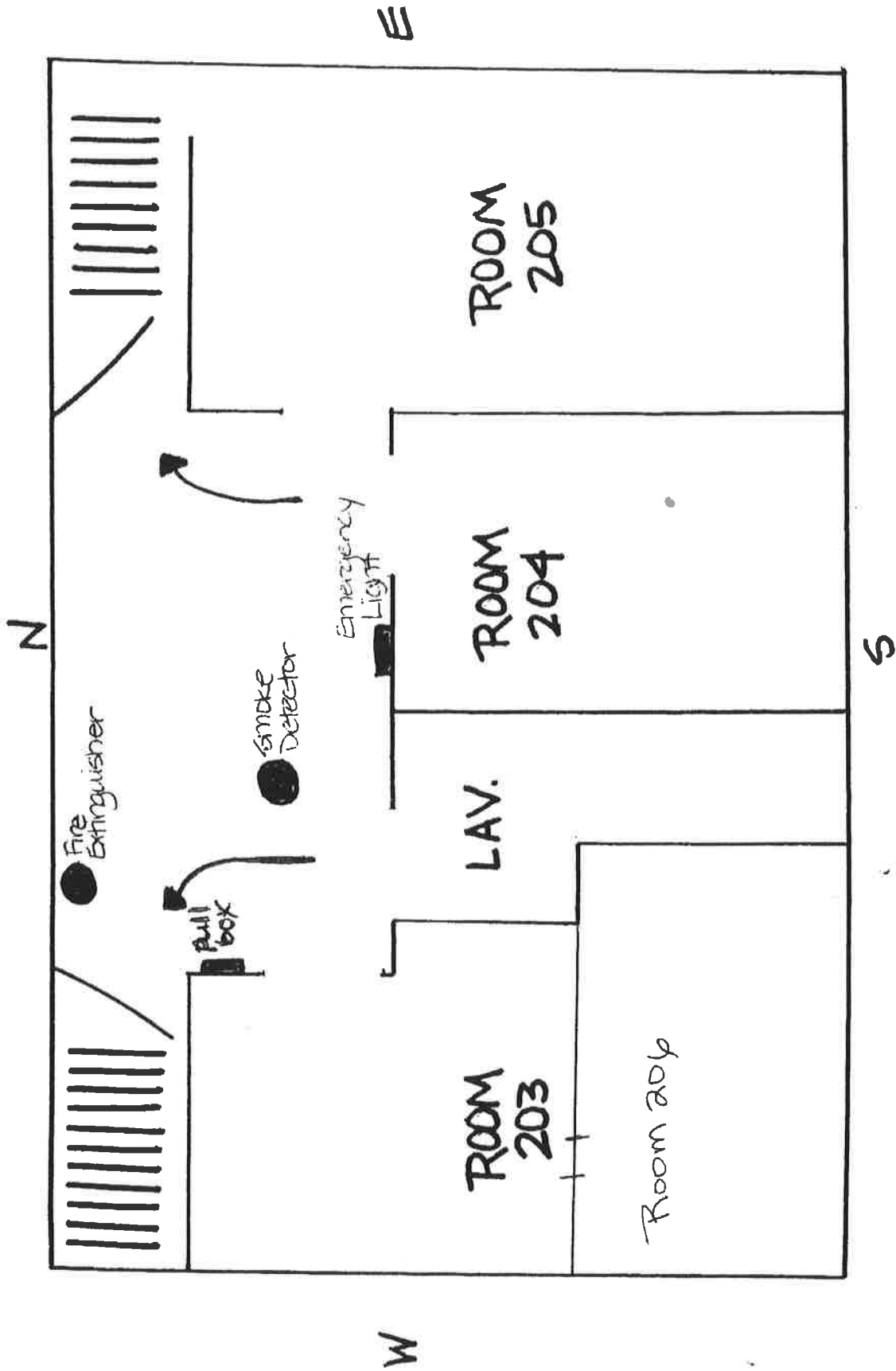


# SOUTHSIDE CARE CENTER



FIRST FLOOR EVACUATION PLAN

# SOUTHSIDE CARE CENTER



SECOND FLOOR EVACUATION PLAN

ZONE 1 OF 3 ZONES

**FIRE/SMOKE ZONE\* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES**

2000 LIFE SAFETY CODE

|  |                                     |
|--|-------------------------------------|
| FACILITY<br><u>SOUTHSIDE CARE CENTER</u> | BUILDING<br><u>01-MAIN BUILDING</u> |
| ZONE(S) EVALUATED<br><u>BASEMENT</u>     |                                     |
| PROVIDER/VENDOR NO.<br><u>24E507</u>     | DATE OF SURVEY<br><u>07/13/2016</u> |

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

**Step 1:** Determine Occupancy Risk Parameter Factors - Use Table 1.

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

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

**Step 2:** Compute Occupancy Risk Factor (F) - Use Table 2.

- A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.  
B. Compute F by multiplying the risk factor values as indicated in Table 2.

| TABLE 2. OCCUPANCY RISK FACTOR CALCULATION |   |   |   |   |   |              |
|--|---|---|---|---|---|--------------|
| OCCUPANCY RISK                             | M | D | L | T | A | F            |
|  | □ | □ | □ | □ | □ | = <u>1.6</u> |

**Step 3:** Compute Adjusted Building Status (R) - Use Table 2.

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

| TABLE 3A. (NEW BUILDINGS)      |
|--------------------------------|
| $1.0 \times \square = \square$ |

| TABLE 3B. (EXISTING BUILDINGS) |
|--------------------------------|
| $0.6 \times \square = \square$ |

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

|   |                           |                           |
|---|---------------------------|---------------------------|
| SURVEYOR SIGNATURE<br><u>Robert P. ... FIRE SAFETY RESOURCES, LLC</u> | TITLE<br><u>PRESIDENT</u> | DATE<br><u>07/14/2016</u> |
| FIRE AUTHORITY SIGNATURE  | TITLE                     | DATE                      |

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

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

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

- NOTE:**
- <sup>a</sup> Use (0) where parameter 5 is -10.
  - <sup>b</sup> Use (0) where parameter 10 is -8.
  - <sup>c</sup> Use (0) on floor with fewer than 31 patients (existing buildings only)
  - <sup>d</sup> Use (0) where parameter 4 is -10.

- <sup>e</sup> Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200")
- <sup>f</sup> Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.
- <sup>g</sup> Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

For SI units: 1 ft = 0.3048 m

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

- A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as 1/2 the corresponding value circled in Table 4.
- B. Add the four columns, keeping in mind that any negative numbers deduct.
- C. Transfer the resulting total values for S<sub>1</sub>, S<sub>2</sub>, S<sub>3</sub>, S<sub>4</sub> to blocks labeled S<sub>1</sub>, S<sub>2</sub>, S<sub>3</sub>, S<sub>4</sub> in Table 7 on page 4 of this sheet.

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

| Zone Location   | Containment (S <sub>a</sub> ) |        | Extinguishment (S <sub>b</sub> ) |        | People Movement (S <sub>c</sub> ) |        |
|---|-------------------------------|--------|----------------------------------|--------|-----------------------------------|--------|
|   | New                           | Exist. | New                              | Exist. | New                               | Exist. |
| 1 <sup>st</sup> story                                 | 11                            | 5      | 15(12) <sup>a</sup>              | 4      | 8(5) <sup>a</sup>                 | 1      |
| 2 <sup>nd</sup> or 3 <sup>rd</sup> story <sup>b</sup> | 15                            | (9)    | 17(14) <sup>a</sup>              | (6)    | 10(7) <sup>a</sup>                | (3)    |
| 4 <sup>th</sup> story or higher                       | 18                            | 9      | 19(16) <sup>a</sup>              | 6      | 11(8) <sup>a</sup>                | 3      |

- a. Use ( ) in zones that do not contain patient sleeping rooms.
- b. For a 2<sup>nd</sup> story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values set shall be permitted to be used: S<sub>a</sub>=7, S<sub>b</sub>=10, and S<sub>c</sub>=7

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

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

|  |       |   |     | Yes                           | No |
|--|-------|---|-----|-------------------------------|----|
| Containment Safety (S <sub>1</sub> )     | minus | Mandatory Containment (S <sub>a</sub> )     | ≥ 0 | $S_1 - S_a = C$<br>12 - 9 = 3 | ✓  |
| Extinguishment Safety (S <sub>2</sub> )  | minus | Mandatory Extinguishment (S <sub>b</sub> )  | ≥ 0 | $S_2 - S_b = E$<br>8 - 6 = 2  | ✓  |
| People Movement Safety (S <sub>3</sub> ) | minus | Mandatory People Movement (S <sub>c</sub> ) | ≥ 0 | $S_3 - S_c = P$<br>5 - 3 = 2  | ✓  |
| General Safety (S <sub>4</sub> )         | minus | Occupancy Risk (R)                          | ≥ 0 | $S_4 - R = G$<br>9 - 1 = 8    | ✓  |

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

| <b>CONCLUSIONS</b>  |  |
|---|--|
| 1.  | <input checked="" type="checkbox"/> All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the <i>Life Safety Code</i> .*                   |
| 2.  | <input type="checkbox"/> One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the <i>Life Safety Code</i> .* |
| *The equivalency covered by this worksheet includes the majority of considerations covered by the <i>Life Safety Code</i> . There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility. |  |

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0242. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

ZONE 2 OF 3 ZONES

**FIRE/SMOKE ZONE\* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES**

2000 LIFE SAFETY CODE

|  |                                     |
|--|-------------------------------------|
| FACILITY<br><u>SOUTHSIDE CARE CENTER</u> | BUILDING<br><u>01-MAIN BUILDING</u> |
| ZONE(S) EVALUATED<br><u>FIRST FLOOR</u>  |                                     |
| PROVIDER/VENDOR NO.<br><u>24E507</u>     | DATE OF SURVEY<br><u>07/13/2016</u> |

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

**Step 1:** Determine Occupancy Risk Parameter Factors - Use Table 1.

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

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

**Step 2:** Compute Occupancy Risk Factor (F) - Use Table 2.

- A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.  
B. Compute F by multiplying the risk factor values as indicated in Table 2.

|                |            |            |            |            |            |               |
|----------------|------------|------------|------------|------------|------------|---------------|
|                | <b>M</b>   | <b>D</b>   | <b>L</b>   | <b>T</b>   | <b>A</b>   | <b>F</b>      |
| OCCUPANCY RISK | <u>1.6</u> | <u>1.5</u> | <u>1.1</u> | <u>4.0</u> | <u>1.2</u> | = <u>12.7</u> |

**Step 3:** Compute Adjusted Building Status (R) - Use Table 2.

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

|       |           |             |
|-------|-----------|-------------|
|       | <b>F</b>  | <b>R</b>    |
| 1.0 X | <u>  </u> | = <u>  </u> |

|       |             |                         |
|-------|-------------|-------------------------|
|       | <b>F</b>    | <b>R</b>                |
| 0.6 X | <u>12.7</u> | = <u>7.6</u> = <u>8</u> |

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

|   |                           |                           |
|---|---------------------------|---------------------------|
| SURVEYOR SIGNATURE<br><u>Robert J. Umbalato</u>               | TITLE<br><u>PRESIDENT</u> | DATE<br><u>07/14/2016</u> |
| FIRE AUTHORITY SIGNATURE<br><u>FIRE SAFETY RESOURCES, LLC</u> | TITLE                     | DATE                      |



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

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

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

**NOTE:** <sup>a</sup> Use (0) where parameter 5 is -10.

<sup>b</sup> Use (0) where parameter 10 is -8.

<sup>c</sup> Use (0) on floor with fewer than 31 patients (existing buildings only)

<sup>d</sup> Use (0) where parameter 4 is -10.

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

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

<sup>g</sup> Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

For SI units: 1 ft = 0.3048 m

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

- A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as 1/2 the corresponding value circled in Table 4.
- B. Add the four columns, keeping in mind that any negative numbers deduct.
- C. Transfer the resulting total values for S<sub>1</sub>, S<sub>2</sub>, S<sub>3</sub>, S<sub>6</sub> to blocks labeled S<sub>1</sub>, S<sub>2</sub>, S<sub>3</sub>, S<sub>6</sub> in Table 7 on page 4 of this sheet.

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

| Zone Location   | Containment (S <sub>a</sub> ) |        | Extinguishment (S <sub>b</sub> ) |        | People Movement (S <sub>c</sub> ) |        |
|---|-------------------------------|--------|----------------------------------|--------|-----------------------------------|--------|
|   | New                           | Exist. | New                              | Exist. | New                               | Exist. |
| 1 <sup>st</sup> story                                 | 11                            | 5      | 15(12) <sup>a</sup>              | 4      | 8(5) <sup>a</sup>                 | 1      |
| 2 <sup>nd</sup> or 3 <sup>rd</sup> story <sup>b</sup> | 15                            | 9      | 17(14) <sup>a</sup>              | 6      | 10(7) <sup>a</sup>                | 3      |
| 4 <sup>th</sup> story or higher                       | 18                            | 9      | 19(16) <sup>a</sup>              | 6      | 11(8) <sup>a</sup>                | 3      |

- a. Use ( ) in zones that do not contain patient sleeping rooms.
- b. For a 2<sup>nd</sup> story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values set shall be permitted to be used: S<sub>a</sub>=7, S<sub>b</sub>=10, and S<sub>c</sub>=7

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

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

| TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION |       |                                     |          | Yes                            | No |
|--|-------|-------------------------------------|----------|--------------------------------|----|
| Containment Safety ( $S_1$ )                     | minus | Mandatory Containment ( $S_c$ )     | $\geq 0$ | $S_1 - S_a = C$<br>16 - 5 = 11 | ✓  |
| Extinguishment Safety ( $S_2$ )                  | minus | Mandatory Extinguishment ( $S_c$ )  | $\geq 0$ | $S_2 - S_b = E$<br>13 - 4 = 9  | ✓  |
| People Movement Safety ( $S_3$ )                 | minus | Mandatory People Movement ( $S_c$ ) | $\geq 0$ | $S_3 - S_c = P$<br>4 - 1 = 3   | ✓  |
| General Safety ( $S_4$ )                         | minus | Occupancy Risk ( $R$ )              | $\geq 0$ | $S_4 - R = G$<br>13 - 8 = 5    | ✓  |

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

| CONCLUSIONS   |  |
|---|--|
| 1.  | <input checked="" type="checkbox"/> All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the <i>Life Safety Code</i> .*                   |
| 2.  | <input type="checkbox"/> One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the <i>Life Safety Code</i> .* |
| *The equivalency covered by this worksheet includes the majority of considerations covered by the <i>Life Safety Code</i> . There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility. |  |

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0242. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

ZONE 3 OF 3 ZONES

**FIRE/SMOKE ZONE\* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES**

2000 LIFE SAFETY CODE

|  |                                     |
|--|-------------------------------------|
| FACILITY<br><u>SOUTHSIDE CARE CENTER</u> | BUILDING<br><u>01-MAIN BUILDING</u> |
| ZONE(S) EVALUATED<br><u>SECOND FLOOR</u> |                                     |
| PROVIDER/VENDOR NO.<br><u>24E50T</u>     | DATE OF SURVEY<br><u>07/13/2016</u> |

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

**Step 1:** Determine Occupancy Risk Parameter Factors - Use Table 1.

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

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

**Step 2:** Compute Occupancy Risk Factor (F) - Use Table 2.

- A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.  
B. Compute F by multiplying the risk factor values as indicated in Table 2.

| TABLE 2. OCCUPANCY RISK FACTOR CALCULATION |            |            |            |            |            |   |            |
|--|------------|------------|------------|------------|------------|---|------------|
|  | M          | D          | L          | T          | A          | F |            |
| OCCUPANCY RISK                             | <u>1.0</u> | <u>1.2</u> | <u>1.2</u> | <u>4.0</u> | <u>1.2</u> | = | <u>6.9</u> |

**Step 3:** Compute Adjusted Building Status (R) - Use Table 2.

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

| TABLE 3A. (NEW BUILDINGS) |                      |                        |
|---------------------------|----------------------|------------------------|
|                           | F                    | R                      |
| 1.0 X                     | <input type="text"/> | = <input type="text"/> |

| TABLE 3B. (EXISTING BUILDINGS) |            |                  |
|--------------------------------|------------|------------------|
|                                | F          | R                |
| 0.6 X                          | <u>6.9</u> | = <u>4.1</u> = 5 |

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

|   |                           |                           |
|---|---------------------------|---------------------------|
| SURVEYOR SIGNATURE<br><u>Richard J. Smollett</u>              | TITLE<br><u>PRESIDENT</u> | DATE<br><u>07/14/2016</u> |
| FIRE AUTHORITY SIGNATURE<br><u>FIRE SAFETY RESOURCES, LLC</u> | TITLE                     | DATE                      |

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

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

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

- NOTE:**
- <sup>a</sup> Use (0) where parameter 5 is -10.
  - <sup>b</sup> Use (0) where parameter 10 is -8.
  - <sup>c</sup> Use (0) on floor with fewer than 31 patients (existing buildings only)
  - <sup>d</sup> Use (0) where parameter 4 is -10.

- <sup>e</sup> Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200")
- <sup>f</sup> Use ( ) if the area of Class B or C Interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.
- <sup>g</sup> Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

For SI units: 1 ft = 0.3048 m

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

- A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as 1/2 the corresponding value circled in Table 4.
- B. Add the four columns, keeping in mind that any negative numbers deduct.
- C. Transfer the resulting total values for S<sub>1</sub>, S<sub>2</sub>, S<sub>3</sub>, S<sub>4</sub> to blocks labeled S<sub>1</sub>, S<sub>2</sub>, S<sub>3</sub>, S<sub>4</sub> in Table 7 on page 4 of this sheet.

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

| Zone Location   | Containment (S <sub>a</sub> ) |        | Extinguishment (S <sub>b</sub> ) |        | People Movement (S <sub>c</sub> ) |        |
|---|-------------------------------|--------|----------------------------------|--------|-----------------------------------|--------|
|   | New                           | Exist. | New                              | Exist. | New                               | Exist. |
| 1 <sup>st</sup> story                                 | 11                            | 5      | 15(12) <sup>a</sup>              | 4      | 8(5) <sup>a</sup>                 | 1      |
| 2 <sup>nd</sup> or 3 <sup>rd</sup> story <sup>b</sup> | 15                            | (9)    | 17(14) <sup>a</sup>              | (6)    | 10(7) <sup>a</sup>                | (3)    |
| 4 <sup>th</sup> story or higher                       | 18                            | 9      | 19(16) <sup>a</sup>              | 6      | 11(8) <sup>a</sup>                | 3      |

- a. Use ( ) in zones that do not contain patient sleeping rooms.
- b. For a 2<sup>nd</sup> story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values set shall be permitted to be used: S<sub>a</sub>=7, S<sub>b</sub>=10, and S<sub>c</sub>=7

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

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

| TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION |       |                                   |          | Yes                           | No |
|--|-------|-----------------------------------|----------|-------------------------------|----|
| Containment Safety ( $S_1$ )                     | minus | Mandatory Containment ( $S$ )     | $\geq 0$ | $S_1 - S_a = C$<br>10 - 9 = 1 | ✓  |
| Extinguishment Safety ( $S_2$ )                  | minus | Mandatory Extinguishment ( $S$ )  | $\geq 0$ | $S_2 - S_b = E$<br>8 - 6 = 2  | ✓  |
| People Movement Safety ( $S_3$ )                 | minus | Mandatory People Movement ( $S$ ) | $\geq 0$ | $S_3 - S_c = P$<br>4 - 3 = 1  | ✓  |
| General Safety ( $S_4$ )                         | minus | Occupancy Risk ( $R$ )            | $\geq 0$ | $S_4 - R = G$<br>7 - 5 = 2    | ✓  |

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

| CONCLUSIONS   |  |
|---|--|
| 1.  | <input checked="" type="checkbox"/> All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the <i>Life Safety Code</i> .*                   |
| 2.  | <input type="checkbox"/> One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the <i>Life Safety Code</i> .* |
| *The equivalency covered by this worksheet includes the majority of considerations covered by the <i>Life Safety Code</i> . There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility. |  |

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0242. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 5941  
May 5, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number SE507025

Dear Mr. Musser:

The above facility was surveyed on April 18, 2016 through April 21, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.



Southside Care Center

May 5, 2016

Page 2

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, P.O. Box 64900, St Paul MN, 55164-0900. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gloria Derfus, Unit Supervisor at (651) 201-3792.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Kate Johnston", with a long, sweeping horizontal flourish extending to the right.

Kate JohnsTon, Program Specialist  
Program Assurance Unit  
Licensing and Certification Program  
Health Regulation Division  
85 East Seventh Place, Suite 220  
P.O. Box 64900  
St. Paul, Minnesota 55164-0900  
kate.johnston@state.mn.us  
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility  
Licensing and Certification File



Minnesota  
Department  
of Health

June 13, 2016

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

RE: Project Number SE507025

Dear Mr. Musser:

On April 21, 2016, a survey was completed at your facility. You have alleged that the deficiencies cited on that survey by the Minnesota Department of Health, Licensing and Certification Program staff (F tags) have been corrected. We are accepting your plan of correction and presume that your facility will achieve substantial compliance.

Sincerely,

A handwritten signature in cursive script that reads "Gloria Derfus".

Gloria Derfus, Unit Supervisor  
Licensing and Certification Program  
Health Regulation Division  
Telephone: 651-201-3792 Fax: 651-215-9697

cc: Licensing and Certification File

POCA HEALTH SURVEY.ORG

Received 6-13-16

Minnesota Department of Health

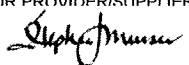
|  |  |  |   |
|--|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>00780</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY COMPLETED<br><br><b>04/21/2016</b> |
|--|--|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SOUTHSIDE CARE CENTER</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2644 ALDRICH AVENUE SOUTH<br/>MINNEAPOLIS, MN 55408</b> |
|--|---|

| (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) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

|       |   |       |   |  |
|-------|---|-------|---|--|
| 3 000 | <p><b>INITIAL COMMENTS</b></p> <p>*****ATTENTION*****</p> <p><b>BOARDING CARE HOME LICENSING CORRECTION ORDER</b></p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p><b>INITIAL COMMENTS:</b><br/>On April 19, 20, and 21, 2016 surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health,</p> | 3 000 | <div data-bbox="982 588 1437 892" style="border: 2px solid black; padding: 10px; text-align: center;"> <p><b>RECEIVED</b></p> <p><b>JUN 14 2016</b></p> <p><b>COMPLIANCE MONITORING DIVISION<br/>LICENSE AND CERTIFICATION</b></p> </div> |  |
|-------|---|-------|---|--|

Noted by Jennifer 6-13-16

|  |                               |                               |
|--|-------------------------------|-------------------------------|
| Minnesota Department of Health<br>LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br> | TITLE<br><b>Administrator</b> | (X6) DATE<br><b>5/19/2016</b> |
|--|-------------------------------|-------------------------------|

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>00780</b>  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                               |  | (X3) DATE SURVEY COMPLETED<br><br><b>04/21/2016</b> |
|--|---|---|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SOUTHSIDE CARE CENTER</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2644 ALDRICH AVENUE SOUTH<br/>MINNEAPOLIS, MN 55408</b> |  |   |
| (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) COMPLETE DATE                                  |
| 3 000  | Continued From page 1<br><br>Division of Compliance Monitoring, Licensing and Certification Program, P.O. Box 64900, St Paul, MN 55164-0900.  | 3 000   |  |   |
| 3 601  | <p>MN St. Statute 144.56 Subp. 2c Tuberculosis Prevention And Control</p> <p>(a) A boarding care home must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.</p> <p>(b) Written compliance with this subdivision must be maintained by the boarding care home.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on document review, the facility failed to ensure Mantoux testing was completed for 3 of 5</p> | 3 601   | <p>3601 - a formal tuberculosis control plan has been updated and will be reviewed and revised annually to ensure Mantoux testing to be completed by all employees. This plan will also include pre-employment screening and new admissions. Southside has no regular volunteers As of the date of this submission, all employees and residents have been screened for signs and symptoms of Tuberculosis. All employees and residents will be provided a Mantoux test annually but no later than January of every year.</p> | 5/17/16   |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>00780</b>                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____   | (X3) DATE SURVEY COMPLETED<br><br><b>04/21/2016</b> |
|--|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SOUTHSIDE CARE CENTER</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2644 ALDRICH AVENUE SOUTH<br/>MINNEAPOLIS, MN 55408</b> |   |   |
| (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) COMPLETE DATE                                  |
| 3 601  | Continued From page 2<br>employees (E1, E2, E3) .<br><br>Findings include:<br><br>A review of E1's employee file indicated a hire date of 1/4/16 and a Tuberculosis (TB) symptom screen was completed on 1/4/16. There was no indication of a TB skin test completed.<br><br>A review of E2's employee file indicated a hire date of 2/4/15. There was no record of a first-step TB skin test.<br><br>E3's TB symptom screen and skin tests were requested and not provided by the facility.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 3 601   |   |   |
| 31145  | MN Rule 4655.7830 Subp. 4 Medication Containers; Out of date medications<br><br>Subp. 4. Out of date medications. Medications having a specific expiration date shall not be used after the date of expiration.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure expired medications were not given to 2 of 2 residents (R10, R4) reviewed for medication storage.<br><br>Findings include:<br><br>R10<br>On 4/19/16, at 4:24 p.m. during medication      | 31145   | 31145 - Southside Care Center employs the services of Omnicare Pharmacy for all controlled drugs, records, receipts and consults. |   |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>SOUTHSIDE CARE CENTER</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2644 ALDRICH AVENUE SOUTH<br/>MINNEAPOLIS, MN 55408</b> |   |   |
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| 31145  | <p>Continued From page 3</p> <p>storage observation, a Novolog insulin (a medication for the treatment of diabetes) FlexPen was observed in the top drawer of the medication cart that was labeled with R10's name and as opened on 3/5/16, and expired on 4/7/16.</p> <p>On 4/19/16, at 4:36 p.m. licensed practical nurse (LPN)-A was observed putting the Novolog insulin (a medication for the treatment of diabetes) FlexPen on shelf above nurses desk. The area was open to the corridor between the kitchen and the dining room, and directly across from resident room 102. From 5:30 to 6:00 p.m. R14 and registered nurse (RN)-A walked between the kitchen and the dining room delivering supper trays. At 6:00 p.m. the Novolog FlexPen was visible on shelf over the nurse's desk. At 7:08 p.m. the Novolog insulin FlexPen was no longer on shelf over the nurse's desk</p> <p>R10's quarterly Minimum Data Set (MDS) dated 3/2/16, indicated R10 had diagnosis of diabetes. The MDS indicated R10 had received insulin injections seven out of seven days.</p> <p>The Physician's Orders signed 3/3/16, indicated R10 was to have blood sugars (BS) checked three times a day before meals and receive Novolog insulin as needed based on a sliding scale. For BS=200-250 give two units, BS=251-300 give four units, BS=301-350 give six units, BS =351-400 give eight units, BS=401-450 give ten units, BS =451-500 give 12 units.</p> <p>A review of April 2016, Medication Administration Record (MAR) indicated R10 received two units of NovoLog insulin on 4/14/16, at 11:30 a.m. for BS of 222.</p> <p>On 4/19/16, at 4:30 p.m. LPN-A verified the</p> | 31145   | <p>All nurses and TMA's have been provided with additional education regarding disposal of expired and/or discontinued medication as of May 17, 2016.</p> <p>All TMA's and licenses personnel are required to act under facility policy regarding and environmental regulation applied to the destruction medication</p> <p>The policy includes reviewing the manufacturers expiration dates and notating shell/ storage expiration dates for varied medication including but not limited to inhalers, eye drops, and insulins.</p> <p>The Omnicare Pharmacy policy and procedure is placed in front of the MAR in access to all qualified personnel.</p> | 5/17/16   |

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| 31145  | <p>Continued From page 4</p> <p>Novolog FlexPen was dated opened on 3/5/16, and 4/7/16, was written as the date that the FlexPen expired. LPN-A also verified the MAR indicated R10 had received 2 units of insulin on 4/14/16.</p> <p>R4<br/>On 4/19/16, at 4:24 p.m. during medication storage observation, an Advair Diskus 500-50 micrograms (mcg) inhaler (a inhaled steroid for the treatment of respiratory disease) was observed in the top drawer of the medication cart that was labeled with R4's name and as opened on 3/16/16. The counter on the disk indicated that were 30 doses left in the inhaler. On 4/19/16, at 4:30 p.m. LPN-A verified the Advair inhaler was dated as opened on 3/16/16, and indicated it did not expire until 8/2017, or all doses were used.</p> <p>On 4/20/16, at 8:15 a.m. trained medication aide (TMA)-A was observed to give R4 an inhaler at the dining room table per R4's request. When TMA-A brought the inhaler back to the medication cart TMA-A showed surveyor that the in haler was Advair Diskus 500-50 mcg dated opened 3/16/16, with 29 doses left. When TMA-A was asked how long Advair Diskus was good for after being removed from foil package, TMA-A said, "Let me ask my nurse." TMA-A verified there was an unopened Advair Diskus for R4 in the medication cart. The director of nurses (DON) stated, "I do not know when it expires let me find out."</p> <p>R4's quarterly MDS dated 3/16/16, indicated R10 had diagnosis of chronic obstructive pulmonary disease. The Physician Orders signed 3/3/16, instructed staff that R4 was to receive Advair Diskus 500-50 micrograms (mcg), one puff twice a day and to rinse mouth after use.</p> | 31145   | <p>Southside has identified a seperately locked, permanently affixed compartment for storage of drugs to be discarded. This location will be under the supervision of the Director or Nursing. Use will begin immediately.</p> | 5/17/16   |

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| 31145  | <p>Continued From page 5</p> <p>During interview on 4/20/16, at 8:30 a.m. the DON stated per pharmacy Advair Diskus was good for 45 days after it was removed from the foil package. Requested copy of pharmacy policy.</p> <p>During interview on 4/20/16, at 9:09 a.m. the DON provided copy of Omnicare Recommended Minimum Medication Storage Parameters revised 3/31/15. RN-A verified that Advair Diskus was to be discarded 30 days after foil package was opened but stated medication was not expired. DON stated thought the Novolog was discontinued. DON acknowledged that the NovoLog was expired prior to 4/14/16, when it was last used. DON stated, "I expect all nurses and TMA's to check expiration dates and remove expired medications from the cart and dispose of them properly."</p> <p>Omicare Recommended Minimum Medication Storage Parameters revised 3/31/15, indicated staff regarding Advair Diskus "Store between 68-77 [degrees Fahrenheit] (20-25 degrees Celsius) in a dry place. Date the Diskus when removed from the foil pouch and discard 1 month after removal from foil pouch or after all blisters have been used, whichever comes first."</p> <p>Omicare Insulin Storage Recommendations revised 3/15/16, instructed staff that insulin cartridge or pens expire 28 days after being opened.</p> <p>Medication administration dated March 2013, instructed staff, "Medications that are to be discarded will be sorted by hazardous and non-hazardous categories and placed in the appropriate bins. The bins are stored in a locked area and are picked -up regularly by a licensed</p> | 31145   |   |                    |



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| 31145  | Continued From page 6<br><br>hauler."<br><br>The package insert for the NovoLog Flexpen from Novo Nordisk dated April 2015, directed the user to: "Do keep NovoLog FlexPen at temperatures below 86°F (30°C) for up to 28 days once it is punctured."<br><br>The package insert for Advair Diskus from GlaxoSmithKline dated April 2014, directed the user to:<br>· "Store ADVAIR DISKUS at room temperature between 68°F and 77°F (20°C and 25°C). Keep in a dry place away from heat and sunlight.<br>· Store ADVAIR DISKUS in the unopened foil pouch and only open when ready for use.<br>· Safely throw away ADVAIR DISKUS in the trash 1 month after you open the foil pouch or when the counter reads 0, whichever comes first."<br><br>SUGGESTED METHOD FOR CORRECTION:<br>The director of nursing could ensure that staff are inserviced as to their responsibility to administer medications according to facility policy and then audit this service to ensure that medications are being provided as indicated and take action as needed.<br><br>TIME PERIOD FOR CORRECTION: Thirty (30) days. | 31145   |   |   |
| 31460  | MN Rule 4655.9000 Subp. 2 Housekeeping; Cleaning Program<br><br>Subp. 2. Development of cleaning program. A program shall be established for routine housekeeping. Besides the daily duties, the program shall include policies and procedures for any special cleaning necessary.   | 31460   | 31460 - SouthsideCare Center makes every effort to ensure that residents have a safe and clean environment.<br><br>Disinfectant wipes have been made available to residents who have requested them to be available. We will continue to monitor resident concerns raised individually or through the Resident Council.<br><br>at residents | ongoing   |

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|--------------------|--|---------------|---|-----------------------------|
| 31460              | <p>Continued From page 7</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview and document review, the facility failed to ensure resident rooms, hallways, common areas and bathrooms were maintained in a safe and sanitary manner. This had the potential to affect all 16 residents residing in the facility.</p> <p>Findings include:</p> <p>During an observation on 4/19/16, at 1:10 p.m., the main floor bathroom behind the nurse desk had a strong urine odor present that permeated out into the hallway near the dining room. There was a soiled brief present in the bathroom garbage can. During a subsequent observation at 4:10 p.m., Urine odor was present upon entrance to the front door of the building. The soiled brief was still in the garbage can.</p> <p>During an observation on 4/20/16, at 7:25 a.m., the following was identified. The hallway outside the main floor bathroom again had a strong urine odor. In the garbage can was a pair of women's underpants. At 8:35 a.m. the main floor bathroom near the entrance to the facility had a dark red substance that looked like blood splattered on the toilet seat and toilet lid.</p> <p>A review of the facility 's Resident Council Minutes dated 3/24/16, indicated an unidentified resident expressed concerns about the upstairs bathroom and stated, "it is always dirty." The minutes further indicated R15 voiced concerns regarding the downstairs bathrooms and indicated they were not clean. The notes indicated "perhaps [Housekeeper (HK)-A] and</p> | 31460         | <p>The carpet in Room 102 across from the Program Managers/DON's desk has been scheduled to be replaced with a new floor. A contract has been consumated with Home Depot - Order # H2808-9422 to be scheduled and completed by June 3rd, 2016. This carpet is the source of much of the odors on that area of the building and will be a cleaner and easier surface to maintain.</p> <p>The carpet in Room 102 across from the Program Managers/DON's desk has been scheduled to be replaced with a new floor. A contract has been consumated with Home Depot - Order # H2808-9422 to be scheduled and completed by June 3rd. This carpet is the source of much of the odors on that area of the building and will be a cleaner and easier surface to maintain.</p> | <p>6/3/16</p> <p>6/3/16</p> |

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| 31460  | Continued From page 8<br><br>myself (recreational therapist) will try to come up with a solution to solve this problem." However, there was no evidence of follow-up to the concern.<br><br>During an interview on 4/20/16, at 7:51 a.m., R15 stated there were no cleaning staff in the facility on the weekends. She stated the bathrooms "get stinky," and she had asked for wipes to clean the toilet but none had been provided.<br><br>A review of the facility's Cleaning Schedule directed HK-A to clean doors, knobs, night stands, window sills, light fixtures, pipes, soiled walls and sprinkler pipe dust. The schedule for April 2016 was signed daily by HK-A. There was no evidence of a schedule to address areas that required deep cleaning.<br><br>A facility policy regarding deep cleaning were request but none provided.<br><br>TIME PERIOD FOR CORRECTION: Thirty (30) days. | 31460   | This same contract will replace the carpet in the back stairwell and second floor landing. This carpet has been difficult to clean and will be replaced by June 3rd. For both - See attachment J. Southside has contacted carpet cleaners to clean the carpets in Room 101 and the front stairway. These carpets are in fair condition and a cleaning will assist in removing and existing dirt and odors. This will be completed by June 27th.<br><br>A deep cleaning schedule has been developed with the housekeeper and will be monitored by the DON and Administrator. A Housekeeping Policy and updated cleaning schedule are located in Attachments C and D. A cleaning policy for the Kitchen and worksheets are provided in Attachments E, f and G and will be monitored by the Administator and Director of Nursing. | 5/27/16   |
| 31942  | MN Rule 144A.10 Subd. 8b Establish Resident and Family Councils<br><br>Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27.  | 31942   |  | Ongoing   |

