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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XCVS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00780

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/07/2020** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Sarah Grebenc, Unit Supervisor 06/04/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 06/04/2020 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS
F912 - Waived

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 3, 2020

CMS Certification Number (CCN): 24E507

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

Dear Administrator:

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 Medicaid program the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective January 18, 2020 the above facility is certified for:

17 Nursing Facility II Beds(certified Board and care homes delete this note)

Your request for waiver of F731 and F912 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 3, 2020

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

RE: CCN: 24E507
Cycle Start Date: December 4, 2019

Dear Administrator:

On February 7, 2020, the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XCVS

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Facility ID: 00780

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(L1) **24E507**

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(L2) **904343800**

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(L4) **2644 ALDRICH AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55408**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/04/2019** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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A. In Compliance With Program Requirements
Compliance Based On:
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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Shelley Arumba, HFE NE II 01/14/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 02/06/2020 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
01/26/1978
(L24)

23. LTC AGREEMENT BEGINNING DATE
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24. LTC AGREEMENT ENDING DATE
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25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XCVS

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(L9)

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__ 6. Scope of Services Limit
__ 7. Medical Director
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
2/7/20 (L33)

DETERMINATION APPROVAL

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

020499

Electronically delivered
December 30, 2019

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

RE: CCN: 24E507
Cycle Start Date: December 4, 2019

Dear Administrator:

On December 4, 2019, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by March 4, 2020 (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).

In addition, if substantial compliance with the regulations is not verified by June 4, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING _____ B. WING _____	C 12/04/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 12/2/19, through 12/4/19, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 12/2/19, through 12/4/19, a standard survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found not to be in compliance with the federal requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: HE507023C deficiencies issued at F623, F625 and F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		1/18/20

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

Electronically Signed | 01/04/2020

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

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	24E507	A. BUILDING _____ B. WING _____	C 12/04/2019

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F 623	Continued From page 1 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30	F 623		

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F 623	Continued From page 2 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to	F 623		

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F 623	Continued From page 3 effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide written hospital transfer notices to the resident(s) and/or resident's representative who had a facility initiated transfer and failed to accurately notify the Office of the State Long-Term Care Ombudsman (OMB) of hospital transfers for 1 of 1 resident (R165) reviewed for hospitalizations. Findings include: The administrator was interviewed on 12/2/19, at 6:20 p.m. and stated he did not think the facility notified the OMB when R165 was hospitalized in October 2019. R165's Progress Note (PN) dated 10/2/19, indicated R165 fell and was sent to the hospital due to pain in her shoulder. A subsequent PN dated 10/2/19, indicated the facility called the hospital and requested to send R165 to "rehab	F 623	F623 Notice Requirements Before Transfer/Discharge a. The facility will provide resident R165, her representative, and the LTC Office of the Ombudsman, a notice in writing as outlined by regulation 483.15 – Notice of Transfer or Discharge, after the fact, regarding her recent hospitalization this past fall for her temporary transfer to a transitional care facility for needed physical therapy prior to returning to Southside Care Center. The written notice will include the reason for her transfer, the effective date, the location she was sent transferred to, her right to appeal, the contact information for the LTC Ombudsman Office, and the other requirements set forth by regulation 483.15. The facility will use this past transfer as training for staff of what we	

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F 623	Continued From page 4 first" prior to returning to facility. R165's medical record lacked evidence of notification and/or reason regarding transfer, the statement of the residents' appeal rights or information on how an appeal form was obtained, and it lacked the contact information of the Office of the States Long-Term Care Ombudsman. The OMB was interviewed on 12/3/19, at 1:38 p.m. and stated she did not receive any notice of transfer and discharge for R165 during the previous six months. Licensed practical nurse (LPN)-A was interviewed on 12/3/19, at 3:36 p.m. and stated the facility would call to notify the OMB when someone discharged. LPN-A verified they did not have a notice of transfer and discharge process when sending a resident to the hospital. The facility policy regarding transfer of a resident to the hospital was requested, but not provided.	F 623	should have done during the time of the resident's temporary transfer to a TCU for physical therapy. b. All existing and future residents admitted to the facility, their representatives, and the State's LTC Ombudsman will be given a written notice of any future resident transfers or discharges from the facility in compliance with the regulations set forth by regulation 483.15. c. The facility will adopt a written Notice of Transfer Form that fulfills all the requirements of regulation 483.15 contents of a written notice for all transfers and discharges, notice before transfer, and the timing of the notice. The policies and procedures for all resident transfers and discharges has been reviewed and updated to include the components set forth by regulation 483.15. And all nursing staff at Southside Care Center will be educated on the use of the transfer and discharge form and notifications to the resident, resident's representative and the State Office of the LTC Ombudsman. d. The Administrator or designee will complete a weekly audit of all resident transfers and discharges reviewing for written Notices of Transfer or Discharge which properly notifies the resident, the resident's representative, and the Office of the State Long-term Care Ombudsman in writing for all hospitalizations, transfers,	

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F 623	Continued From page 5	F 623	or discharges. Audits will be reviewed monthly and the frequency of continued audits will be modified depending of the audit results as discussed in the quarterly Quality Assurance meetings.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 625		1/18/20

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F 625	Continued From page 6 Based on interview and document review, the facility failed to provide written notice of the facility's bed hold policy to resident or resident's representative for 1 of 1 resident (R165) who was hospitalized. Findings include: The administrator was interviewed on 12/2/19, at 6:20 p.m. and stated he did not think the facility issued a written bed hold notice when R165 was hospitalized in October 2019. However, the administrator indicated the facility held R165's bed as she had medical assistance, which meant R165's bed was automatically held for 18 days. R165's Progress Note (PN) dated 10/2/19, indicated R165 fell and was sent to the hospital due to pain in her shoulder. A subsequent PN dated 10/2/19, indicated the facility called the hospital and requested to send R165 to "rehab first" prior to returning to facility. R165's medical record lacked evidence of written bed hold notice following transfer to the hospital on 10/2/19. The ombudsman (OMB) was interviewed on 12/3/19, at 1:38 p.m. and stated she was not aware R165 was admitted to the hospital. Licensed practical nurse (LPN)-A was interviewed on 12/3/19, at 3:36 p.m. and stated the facility did an "automatic" 18 day bed hold for R165. LPN-A verified the facility only sent a facility referral form which included the reason for R165 went to the hospital and medication list.	F 625	F625 Notice of Bed Hold Policy Before / Upon Transfer a. The facility will provide resident R165, and her representative a Notice of Bed-hold Policy in writing as outlined by regulation 483.15, after the fact, regarding her recent hospitalization this past fall for her temporary transfer to a transitional care facility for needed physical therapy prior to returning to Southside Care Center. The written Notice of Bed-hold Policy will include the duration a resident is permitted to return to the facility and resume residency at Southside Care Center. It will also include the reserve bed payment policy, the facilities policy on bed holds as they pertain to hospitalizations and leaves of absence consistent with the regulations set forth by 483.15. The facility will use this past transfer as training for staff of what we should have done during the time of the resident's temporary transfer to a TCU for physical therapy. b. All existing and future residents and their representatives will be given Southside Care Center's Notice of Bed-hold and return policy for all hospitalizations, transfers to other facilities or leaves of absences, to provide in writing the duration a resident is permitted to return to the facility and resume residency at Southside Care Center consistent with the requirements set forth by regulation 483.15. The facility will use this past transfer as training for	

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F 625	Continued From page 7 The facility Bed Hold Policy and Procedure dated 6/2018, indicated at the time of transfer to the hospital the nurse must provide written bed hold policy to the resident.	F 625	staff of what we should have done during the time of the resident was temporary transferred to a TCU for physical therapy. c. The facility will adopt a written Notice of Bed-hold and return policy for all hospitalizations, transfers to other facilities or leaves of absences. This adopted form will be compliant with the regulations set forth by 483.15. The policies and procedures have been reviewed and updated and all nursing staff will be educated on the use of the Notice of Bed-hold form and policy. d. The Administrator or designee will complete a weekly audit of all hospitalizations, transfers, and leaves of absences reviewing for the required notification in writing of the Notice of Bed-hold and return policy for all resident hospitalizations, transfers to other facilities or leaves of absences, which properly notifies the resident, the resident's representative. Audits will be reviewed monthly and the frequency of continued audits will be modified depending of the audit results as discussed in the quarterly Quality Assurance meetings.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		1/18/20

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F 689	Continued From page 8 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to investigate causal factors related to falls and comprehensively reassess and implement additional fall interventions for 1 of 2 residents (R165) reviewed for falls. Findings include: R165's quarterly Minimum Data Set (MDS) dated 8/25/19, identified R165 had intact cognition and diagnoses which included schizophrenia and depression. The MDS indicated R165 was independent with transfers and mobility. The MDS indicated R165 had no past history of falls. R165's Falls Care Area Assessment dated 6/5/19, identified R165 was at risk for falls and directed staff to monitor medication side effects, complete fall risk assessment, monitor for changes and continue current fall interventions. R165's care plan dated 9/23/19, identified R165 was at risk for falls and fell on 9/14/19, and 9/23/19, and directed staff to anticipate and meet needs, ensure call light was within reach and encourage use, staff to ensure prompt response to all request for assistance, encourage participation in activities that promoted exercise, physical activity for strengthening and improved mobility, ensure appropriate footwear was worn, therapy evaluate and treat as ordered, ensure safe environment with even floors, free from	F 689	F689 Free of Accident Hazards/Supervision/Devices a. On Dec. 3, 2019 resident R165's probable causal factor for her fall on 10/2/2019 was determined, resident 165's fall risk assessment and care plan were also updated to include recommended interventions to decrease the resident's risk for future falls. The resident is care planned to use non-skid footwear provided by the facility's nursing staff and to use the recommended assistive device walker issued to the resident by physical therapy for transfers and ambulation as needed and recommended by PT and nursing. In small areas, where the walker will not fit such as the bathroom, the resident is care planned to use grab bars in the bathroom instead of her walker. The resident is also care planned to ask staff for assistance when needed. The resident currently has the ability to effectively communicate and make her needs known. The resident's care plan reflects these recommended interventions and updates and the resident agreed to comply and has demonstrated compliance through multiple observations by nursing. b. All existing and future residents at Southside Care Center will be assessed	

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F 689	Continued From page 9 spills and/ or clutter, adequate light, bed in low position at night personal items within reach, remind to wear light sandals and lift feet. However, R165's care plan lacked evidence of evaluation regarding current risks and interventions following 10/2/19, fall which resulted in right humerus fracture. R165's Fall Risk Evaluation dated 9/29/19, identified R165 was a score of 18 which indicated high falls risk. However, the evaluation lacked evidence of identified interventions to decrease R165's risk for falls and evaluation following R165's fall with right humerus fracture. R165's Fall/ Presumed Fall Incident Report and Interdisciplinary Notes (IN) were reviewed 9/14/19, through 11/26/19, and revealed the following: -The report dated 9/14/19, indicated R165 was "rushing" to the bathroom slipped and landed on buttocks due to having had bare feet. Staff to remind R165 to wear non-skid socks or shoes at all times; -The report dated 9/23/19, indicated R165 was wearing sandals and observed dragging her feet causing R165 to fall on way to the bathroom staff were to replace shoes and remind R165 to lift feet when walking; -The report dated 10/2/19, indicated R165 fell and the causal factor was "not known exactly" care plan would be updated when R165 returned from "rehab;" -The IN dated 10/2/19, indicated R165 fell when in the dining room and reported R165 hit the table and landed on her right hand and shoulder fracture was suspected and paramedics were called and transported R165 to the hospital. A	F 689	and reassessed for their risk of falling. And needed updates and recommended interventions will be made to their care plans based on the assessed risk for falling for all new admissions, readmissions, changes of conditions, and following the MDS schedule for care plan review and updates. c. The policy and procedure for tracking resident falls, investigating the causal factors for resident falls, assessing all residents risk for falls, the timely implementation for interventions to prevent future falls, and the updating of all resident's care plans has been reviewed and remains current. All nursing staff will be educated on the policies and procedures to keep residents safe from accidents, hazards, while providing adequate supervision and promoting the safe use of assistive devices. d. A Registered Nurse will complete a weekly audit of a minimum of 3 residents reviewing their risk assessment for falls and the modifications made to their care plans. Audits will be reviewed monthly and the frequency of continued audits will be modified depending of the audit results as discussed in the quarterly Quality Assurance meetings.	

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F 689	Continued From page 10	F 689		

subsequent IN dated 10/2/19, indicated hospital called and confirmed R165 had humerus fracture. An additional IN dated 10/2/19, indicated the facility requested R165 be sent to "rehab" prior to return to the facility due to incontinence, not very steady walking, always holding onto things while walking which include tables;
-The IN dated 11/26/19, indicated R165 was readmitted to the facility and now used a walker for ambulation further assessment to have been done.

R165's medical record lacked evidence of causal factor following 10/2/19, fall with right humerus fracture evaluation of current interventions and development of immediate interventions.

R165 was observed on 12/2/19, at 1:33 p.m. seated in the dining room then stood up pushed left hand off of table and right hand off of chair R165 moved her walker to the side and held onto the door frame and walked into the bathroom without assistance. R165 was wearing black slippers and had a shuffled gait.

R165 was interviewed on 12/2/19, at 5:34 p.m. and stated she did not remember falling and fracturing her humerus.

Housekeeper (HSK)-A was interviewed via telephone on 12/3/19, at 11:33 a.m. and confirmed he was in the room when R165 fell on 10/2/19. HSK-A explained when R165 stood up from the chair and began walking she lost her balance and tried to hold onto the table however, R165 was unable to steady self and fell down onto the floor.

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F 689	Continued From page 11	F 689		

Licensed practical nurse (LPN)-A was interviewed on 12/3/19, at 2:52 p.m. and stated R165 "sometimes" used her walker and "sometimes she doesn't." LPN-A stated prior to R165's fall on 10/2/19, she would hold onto the rails, furniture and other items when walking. LPN-A indicated he had been "watching her" since she came back and noted no concerns with R165 walking.

The administrator and LPN-A were interviewed on 12/3/19, at 5:10 p.m. The administrator confirmed R165's care plan and fall risk assessment had not been updated since R165's fall on 10/2/19, and/ or return to facility following rehabilitation stay on 11/26/19. The administrator stated it was his expectation for R165's fall risk and care plan to have been updated upon R165's return to the facility.

Registered nurse (RN)-C was interviewed on 12/4/19, at 9:08 a.m. and stated she was present when R165 fell on 10/2/19. RN-C indicated R165 stood up from the chair with a cup of coffee in her hand and lost her balance as she attempted to reach something on the table, however RN-C indicated there was nothing on the table at the time of R165's fall. RN-C stated R165 attempted to lean on the table lost her balance and fell to the floor landing on her right side and began crying due to pain and would not allow staff to touch her. RN-C indicated R165 was transferred to the hospital.

The facility Falls Prevention and Management Program dated 5/30/18, indicated the fall risk assessment should have been completed within

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	24E507	A. BUILDING _____ B. WING _____	C 12/04/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12 24 hours of admission, quarterly, when a change in health status puts them at increased risk for falling such as a fall resulting in serious injury which included fractures and any injury requiring assessment in emergency room and/ or admission to the hospital. The policy indicated monitor and evaluate the care plan at least quarterly and if the interventions were not effective in reducing falls, initiate alternative approaches and update as necessary. The policy indicated post fall assessment would include "redo" fall risk assessment, review the fall prevention interventions and modify the care plan.	F 689		
F 731 SS=F	Waiver-Licensed Nurses 24 hr/day & RN Cvrg CFR(s): 483.35(e)(1)-(7)(f)(1)(2) §483.35(e) Nursing facilities Waiver of requirement to provide licensed nurses on a 24-hour basis. To the extent that a facility is unable to meet the requirements of paragraphs (a)(2) and (b)(1) of this section, a State may waive such requirements with respect to the facility if- §483.35(e)(1) The facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel; §483.35(e)(2) The State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility; §483.35(e)(3) The State finds that, for any periods in which licensed nursing services are	F 731		1/18/20

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F 731	Continued From page 13 not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility; §483.35(e)(4) A waiver granted under the conditions listed in paragraph (e) of this section is subject to annual State review; §483.35(e)(5) In granting or renewing a waiver, a facility may be required by the State to use other qualified, licensed personnel; §483.35(e)(6) The State agency granting a waiver of such requirements provides notice of the waiver to the Office of the State Long-Term Care Ombudsman (established under section 712 of the Older Americans Act of 1965) and the protection and advocacy system in the State for individuals with a mental disorder who are eligible for such services as provided by the protection and advocacy agency; and §483.35(e)(7) The nursing facility that is granted such a waiver by a State notifies residents of the facility and their resident representatives of the waiver. §483.35(f) SNFs Waiver of the requirement to provide services of a registered nurse for more than 40 hours a week. §483.35(f)(1) The Secretary may waive the requirement that a SNF provide the services of a registered nurse for more than 40 hours a week, including a director of nursing specified in paragraph (b) of this section, if the Secretary finds that-	F 731		

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F 731	Continued From page 14 (i) The facility is located in a rural area and the supply of skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area; (ii) The facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week; and (iii) The facility either- (A) Has only patients whose physicians have indicated (through physicians' orders or admission notes) that they do not require the services of a registered nurse or a physician for a 48-hours period or; (B) Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty; (iv) The Secretary provides notice of the waiver to the Office of the State Long-Term Care Ombudsman (established under section 712 of the Older Americans Act of 1965) and the protection and advocacy system in the State for individuals with developmental disabilities or mental disorders; and (v) The facility that is granted such a waiver notifies residents of the facility and their resident representatives of the waiver. §483.35(f)(2) A waiver of the registered nurse requirement under paragraph (f)(1) of this section is subject to annual renewal by the Secretary. This REQUIREMENT is not met as evidenced by: Based on interview and schedule review, the facility failed to provide licensed nurses on a 24 hour basis for 6 of 14 days during a two week	F 731	F731 Waiver-Licensed Nurses 24 Hour/Day & RN Coverage:	

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F 731	Continued From page 15 period reviewed for staffing patterns. Findings Include: The facility "2 Week Schedule" dated 12/1/19, through 12/15/19, indicated the TMA was scheduled to work on 12/1/19, 12/2/19, 12/5/19, 12/11/19, 12/12/19, and 12/15/19. The schedule lacked evidenced of licensed staff scheduled to work during those times. The administrator was interviewed on 12/2/19, at 6:02 p.m. and stated the facility did not have licensed staff working six out of 14 days. The administrator verified this reoccurred every pay period and the facility utilized trained medication aide (TMA) in place of licensed staff for those six days during the overnight shift. The administrator reviewed the facility schedule and verified the TMA was scheduled to work 12/1/19, 12/2/19, 12/5/19, 12/11/19, 12/12/19, and 12/15/19, during the night shift without licensed staff present. The administrator further stated the TMA would call the director of nursing and/ or administrator "when something goes wrong."	F 731	a. Southside Care Center requests an extension of a waiver for the use of a TMA for approximately 6 shifts out of 14 on the overnight shift with licensed nurses (LPNs and RNs) working all remaining nursing shifts throughout the 14 day pay period. Southside Care Center does not need a waiver for the 8 hours of RN in a 24 hour period requirement, the facility has an adequate number of RNs on staff and the retention record to easily continue to fulfill the daily 8 hour requirement for a Registered Nurse. b. The Administrator and Program Manager are continuing to work with Bridges MN Human Resources department to continue to search for and hire additional LPNs and RNs to backfill the overnight shifts currently covered by a TMA. c. The policy and procedure for 24-hours of licensed nursing (RNs or LPNs) coverage at the facility has been reviewed and remains current. The staffing schedule has been reviewed and the overnight staffing need has been identified. All staff in the facility will be educated on this policy. d. The administrator or designee will continue to work with Human Resources on filling the identified shifts with licensed nursing staff for 24-hour coverage with licensed nurses. Every pay period audits of the schedule will continue by the	

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F 731	Continued From page 16	F 731	Program Director or designee, and the continuation of audits will be modified depending of the results as discussed in the quarterly Quality Assurance meetings.	
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the	F 838		1/18/20

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F 838	Continued From page 17 facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to ensure a facility assessment was completed to ensure necessary resources for the care of their residents. This had then potential to affect all 15 residents residing in the facility. Findings include: The facility assessment was requested for review	F 838	F838 Facility Assessment a. A facility-wide assessment determining the resources that are needed for the competent care of residents during both the standard day-to-day operations of the facility and in case of various types of emergencies. The facility will keep this plan updated as	

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F 838	Continued From page 18 and none were provided. During interview on 12/2/19, at 2:00 p.m. the administrator stated the facility-wide assessment had not been completed. No further information was provided.	F 838	needed at a minimum of annually. The facility will also update this plan as necessary in relation to significant operations changes that would necessitate the need to update the plan. The plan will focus on the medical needs of the residents it serves along with the competencies of the staff that care for them. The physical plant will also be taken into consideration as well as the cultural and spiritual needs of residents, and a facility-based and community-based risk assessment while also address all of the required elements as identified in regulation 483.70 b. All existing and future residents will be included as part of the facility-wide assessment determining the resources that are needed for the competent care of residents during day-to-day operations of the facility and in case of emergencies. And this plan will be modified to adapt to any changes in resident population factoring the needs of all residents served. The facility-wide assessment plan will be used to make any needed changes to the operational service provided by staff to the residents it serves at Southside Care Center. c. The policy and procedure for the facility-wide assessment plan used to determine the resources that are needed for the competent care of residents will be updated and reviewed as needed with changes to the operation, the needs of new admissions, and at minimum	

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F 838	Continued From page 19	F 838	annually. All staff in the facility will be educated on this policy. d. The administrator or designee will continue to work on keeping the facility-wide assessment up to date reflecting the residents needs as they change over time. Quarterly audits of the facility-wide assessment will be conducted by the Administrator or designee and the plan will be updated as needed at a minimum of annually. The frequency of the audits will be modified and adjusted as needed depending on the results and discussed in the quarterly Quality Assurance meetings.	
F 841 SS=F	Responsibilities of Medical Director CFR(s): 483.70(h)(1)(2) §483.70(h) Medical director. §483.70(h)(1) The facility must designate a physician to serve as medical director. §483.70(h)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the person who functioned as the medical director was a physician. This deficient practice had the potential to affect all 15 residents currently residing in the facility Findings include: Review of the quality assurance needing notes	F 841	F841 Responsibilities of Medical Director a. The facility is in the process of interviewing two qualified physicians for the Medical Director position at Southside Care Center. The facility will have a new qualified licenses physician in the State of Minnesota hired and under contract on or before January 18, 2020.	1/18/20

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F 841	Continued From page 20 dated 7/1/19, and 10/9/19, indicated RN-A had attended the meetings and signed as the medical director appointed to the facility. The administrator was interviewed on 12/3/19, at approximately 11:00 a.m.. The administrator verified the facility medical director was not a physician, but believed was qualified to be the medical director due to having a doctorate degree. Registered Nurse (RN) -A was interviewed on 12/4/19, at 11:30 AM. RN-A verified she was appointed and acted as the facility's medical director, and verified she was not a physician, but did have a doctorate degree in nursing. RN-A was not aware of the requirement for the medical director to be a physician. A policy regarding qualifications for the medical director was requested but not provided.	F 841	b. The new Medical Director will fulfill the required responsibilities as outlined by regulation 483.70 which includes, but is not limited to, assisting with the coordination of medical care for all of the residents and attending the quarterly Quality Assurance and Performance Improvement (QAPI) meetings. c. The policy and procedures for the qualifications and responsibilities of a medical director have been updated and reviewed. All staff in the facility will be educated on this policy. d. The Administrator or designee will complete an audit a minimum of quarterly verifying that the facility is fulfilling the requirements set forth by regulation 483.70 for the responsibilities and qualifications of a Medical Director. The audit will be reviewed, and the frequency of continued auditing will be determined based on the results and discussed in the quarterly Quality Assurance meetings.	
F 912 SS=B	Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii) §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide at least 80 square feet of usable space in 1 of 6 resident bedrooms occupied by four residents (R11, R3, R7, R6).	F 912	F912 Bedrooms Measure at Least 80 Sq. Ft./ Resident Southside Care Center requests a	1/18/20

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F 912	Continued From page 21 Findings include: Room 102 was observed on 12/2/19, at 12:33 p.m. and was occupied by R11, R3, R7 and R6 and revealed the room contained a dresser and wardrobe for each resident. R3 was interviewed on 12/2/19, at 12:36 p.m. and denied any concerns related to room size and/ or accommodations. R7 was interviewed on 12/2/19, at 12:46 p.m. and stated she had no concerns with her room size. R6 was interviewed on 12/2/19, at 1:19 p.m. and stated she had enough space in her room. R11 was interviewed on 12/2/19, at 1:53 p.m. and denied any concerns related to room size and/ or accommodations. The administrator was interviewed on 12/2/19, at 6:02 p.m. and confirmed room 102 did not meet the square foot requirements of 80 square feet per person. The administrator indicated there were four residents whom currently resided in room 102, however was unable to provide a copy of the waiver.	F 912	continuation of its waiver of providing all residents a minimum of 80 square feet per resident. The original construction date of the facility is approximately 1909 and there are limitations of the physical plant that do not allow for the facility to provide 80 square feet per resident for all residents in the facility. The facility requests that the residents (R11, R3, R7, and R6) residing in room 102 be a part of the continued waiver request.	

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/04/2019. At the time of this survey, Southside Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/04/2020

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

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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Southside Care Center is a 2-story building with a full basement that was built in 1909 and was determined to be of Type V(000) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that are monitored for automatic fire department notification.

The facility has a capacity of 17 beds and had a census of 15 at the time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 161	Continued From page 2	K 161		
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including	K 161		1/18/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/04/2019**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 161	Continued From page 3 basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, this building does not meet the requirement for construction type and height in accordance with the NFPA 101 (2012), Life Safety Code, Section 19.1.6.1. This deficient practice could affect all 15 residents. Findings include: On a facility tour at 11:30 AM on 12/04/2019, it was revealed that the building construction is Type V (000), which does not meet the requirement for a 2-story building. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 161	K161 Building Construction Type and Height Correction not needed. Southside Care Center has achieved a passing FSES score based on the completed report December 16, 2019. A complete FSES/HC report is emailed to the FM.HC.Inspections@state.mn.us email address for Healthcare Fire Inspections State Fire Marshal Division.	
K 225 SS=F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide the proper width of egress	K 225	K225 Stairways and Smokeproof Enclosures	1/18/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/04/2019**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 225	Continued From page 4 stairs per NFPA 101 (2012), Life Safety Code, Section 7.2.2.2.1.1(b). This deficient practice could affect all 15 residents. Findings include: On a facility tour at 11:42 AM on 12/04/2019, it was revealed that the back stairs at the rear exit are only 32" wide. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 225	Correction not needed. Southside Care Center has achieved a passing FSES score based on the completed report December 16, 2019. A complete FSES/HC report is emailed to the FM.HC.Inspections@state.mn.us email address for Healthcare Fire Inspections State Fire Marshal Division.	
K 232 SS=F	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not maintain the minimum width and clear, unobstructed egress corridor per NFPA 101 (2012), Life Safety Code, Sections 19.2.3.4, 19.2.3.5. This deficient practice could affect all 15 residents. Findings Include: On a facility tour at 12:13 PM on 12/04/2019, it was revealed that the first-floor corridor is only 33	K 232	K232 Aisles, Corridor, or Ramp Width Correction not needed. Southside Care Center has achieved a passing FSES score based on the completed report December 16, 2019. A complete FSES/HC report is emailed to the FM.HC.Inspections@state.mn.us email address for Healthcare Fire Inspections State Fire Marshal Division.	1/18/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/04/2019**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 232	Continued From page 5 inches in clear width and not the 48 inches required for this type of facility. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 232		
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not maintain adequate protection of vertical openings to include stairways, elevator shafts, light and ventilation shafts, and chutes between floors per NFPA 101 (2012), Life Safety Code, Section 19.3.1. This deficient practice could affect 15 Residents. Findings Include: On a facility tour at 12:03 PM on 12/04/2019, it was revealed that the wall of the stair enclosures are constructed of plaster on wood lath on wood studs, which does not meet minimum requirements for this type of facility.	K 311	K311 Vertical Openings - Enclosures Correction not needed. Southside Care Center has achieved a passing FSES score based on the completed report December 16, 2019. A complete FSES/HC report is emailed to the FM.HC.Inspections@state.mn.us email address for Healthcare Fire Inspections State Fire Marshal Division.	1/18/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/04/2019**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 311	Continued From page 6 This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 311		

FIRE SAFETY EVALUATION SYSTEM
HEALTH CARE FACILITIES

(NFPA 101A, "Guide on Alternative Approaches to Life Safety" 2013 Edition)

Complete the following worksheets for each fire/smoke zone*.
Where conditions are the same in several zones, one set of worksheets can be used for those zones.
* Fire/smoke zone is a space separated from all other spaces by floors, horizontal exits, or smoke barriers

Step 1 — Complete Cover Sheet using Worksheet 4.7.1.

WORKSHEET 4.7.1 – COVER SHEET

ZONE 1 OF 3 ZONES

NAME OF FACILITY	ADDRESS OF FACILITY		
SOUTHSIDE CARE CENTER	2644 ALDRICH AVE. S, MINNEAPOLIS, MN 55408		
ZONE(S) EVALUATED			
BASEMENT			
PROVIDER/VENDOR NO.	DATE OF SURVEY		
24E507	12/16/2019		
SURVEYOR SIGNATURE	TITLE	OFFICE	DATE
Robert S. Vandette	PRESIDENT	FIRE SAFETY RESOURCES, LLC	12/31/2019
SURVEYOR ID			
FIRE AUTHORITY SIGNATURE	TITLE	OFFICE	DATE
[signature] 12/24/	Fire Safety Supervisor	MN State Fire Marshal	01-14-2020

ADDITIONAL COMMENTS:

CMS FORMS SHALL BE COMPLETED AND RETAINED AS PART OF THE SURVEY RECORD.

Step 2 — Determine Occupancy Risk Parameter Factors using Worksheet 4.7.2.
For each Risk Parameter in Worksheet 7.2, select and circle the appropriate risk factor value.
Choose only one for each of the five Risk Parameters.

WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

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

*A risk factor of 4.0 is charged to any zone that houses patients without any staff in immediate attendance.

Step 3 — Compute Occupancy Risk Factor (F) using Worksheet 4.7.3.
(1) Transfer the circled risk factor values from Worksheet 4.7.2 to the corresponding blocks in Worksheet 4.7.3.
(2) Compute F by multiplying the risk factor values as indicated in Worksheet 4.7.3.

WORKSHEET 4.7.3 - OCCUPANCY RISK FACTOR CALCULATION

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

Step 4 — Compute Adjusted Building Status (R) - Use Worksheets 4.7.4 or 4.7.5.
(1) If building is classified as "NEW" use Worksheet 4.7.4. If building is classified as "Existing" use Worksheet 4.7.5.
(2) Transfer the value of F from Worksheet 4.7.3 to Worksheets 4.7.4 or 4.7.5, as appropriate. Calculate R.
(3) Transfer R to the block labeled R in Worksheet 4.7.9.
(4) In Worksheets 4.7.4 and 4.7.5, results are always rounded up (i.e., 3.2 is rounded to 4.0).

WORKSHEET 4.7.4 ADJUSTED OCCUPANCY RISK FACTOR (NEW)

	F		R
1.0 X	[ ]	=	[ ]

WORKSHEET 4.7.5 ADJUSTED OCCUPANCY RISK FACTOR (EXISTING)

	F		R
0.6 X	[1.6]	=	[1]

Step 5 — Determine Safety Parameter Values using Worksheet 4.7.6.

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

WORKSHEET 4.7.6 – SAFETY PARAMETER VALUES

Safety Parameters	Parameters Values						
1. Construction	Combustible Types III, IV, and V				Non-Combustible Types I and II		
Floor or Zone	000	111	200	211, 2HH	000	111	222, 322, 442
First	-2	0	-2	0	0	2	2
Second	(-7)	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4

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

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

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

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

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

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

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

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200").
For SI Units: 1 ft.² = 0.3048 m²

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

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

[h] Use (0) where zone area ≤ 22,500 ft.² and distance from any point to reach a door in smoke barrier is ≤ 200 ft.

Step 6 — Compute Individual Safety Evaluations using Worksheet 4.7.7.

(1) Transfer each of the 13 circled Safety Parameter Values from Worksheet 4.7.6 to every unshaded block in the line with the corresponding Safety Parameter in Worksheet 4.7.7. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Worksheet 4.7.7 as 1/2 the corresponding value circled in Worksheet 4.7.6.

(2) Add the four columns, keeping in mind that any negative numbers deduct.

(3) Transfer the resulting total values for S1, S2, S3, S4 to blocks labeled S1, S2, S3, S4 in Worksheet 4.7.9 on page 4 of this sheet.

WORKSHEET 4.7.7 - INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-7	-7		-7
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions and 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		5	5	5
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 12	S_2= 10	S_3= 7	S_4= 11

Step 7 — Determine Mandatory Safety Requirement values using Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(1) Using the facility type (i.e., Hospital or Nursing Home), classification (i.e., New, Existing or Rehabilitated) and the floor where the zone is located, circle the appropriate value in each of the three columns found in Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(2) Transfer the three circled values to the blocks marked S_a, S_b, and S_c in Worksheet 4.7.9.

(3) The Mandatory Safety Requirement value for basements are based on the distance of the basement level from the closest level of discharge (See 4.6.1.2 and 4.6.1.3).

WORKSHEET 4.7.8A - MANDATORY SAFETY REQUIREMENTS – NEW HOSPITALS, EXISTING HOSPITALS OR NEW NURSING HOMES

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Existing	New	Existing	New	Existing
1st story	11	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher, but not high rise	18	9	19(16)[a]	6	11(8)[a]	3
High rise	18	17	19(16)[a]	16	11(8)[a]	7

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

b. For a 2nd story zone location in a sprinklered EXISTING hospital, 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: Sa=7, Sb=10, and Sc=7

WORKSHEET 4.7.8B - MANDATORY SAFETY REQUIREMENTS – EXISTING NURSING HOMES

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	0	10	0
2nd story	(2)	(10)	(2)
3rd story	6	14	2
4th story or higher	8	16	2

WORKSHEET 4.7.8C - MANDATORY SAFETY REQUIREMENTS – MAJOR REHABILITATION IN NONSPRINKLERED EXISTING HOSPITALS

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	13	17(14)*	8(5)*
2nd or 3rd story	17	19(16)*	10(7)*
4th story or higher	18	19(16)*	11(8)*

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

Step 8 — Identify Zone Fire Safety Equivalency using Worksheet 4.7.9.

(1) Transfer the three circled values from Worksheet 4.7.8A, 4.7.8B, or 4.7.8C to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.

(2) 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.

WORKSHET 4.7.9 - ZONE FIRE SAFETY EQUIVALENCY EVALUATION

						YES	NO
Containment Safety (S_1)	minus	Mandatory Containment (Sa)	≥ 0	S_1 12 — S_a 2 = C 10		√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (Sb)	≥ 0	S_2 10 — S_b 10 = E 0		√	
People Movement Safety (S_3)	minus	Mandatory People Movement (Sc)	≥0	S_3 7 — S_c 2 = P 5		√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 11 — R 1 = G 10		√	

Step 9 — Evaluate other considerations not previously addressed using Worksheet 4.7.10.
Complete one copy of this separate worksheet for each facility.
For each consideration, select and mark the appropriate column.

WORKSHEET 4.7.10 FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	√		X
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.	√		X
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	√		X
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.	√		X
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	√		X
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 18.3.5.12 and 19.3.5.12.	√		X
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 19.2.9.1.	√		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			√

Step 10 — Determine the equivalency Conclusion to determine if the level of life safety is at least equivalent to that prescribed by the Life Safety Code using Worksheet 4.7.11.

WORKSHEET 4.7.11- CONCLUSIONS

1. ☒ All of the checks in Worksheet 4.7.9 are in the "Yes" column and all applicable considerations in Worksheet 4.7.10 are marked as "Met". The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

2. ☐ All of the checks in Worksheet 4.7.9 are in the "Yes" column and all considerations in Worksheet 4.7.10 marked as "Not Met" have been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

3. ☐ One or more of the checks on Worksheet 4.7.9 are in the "No" column or any considerations in Worksheet 4.7.10 marked as "Not Met" have NOT been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is not shown by this system to be equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

FIRE SAFETY EVALUATION SYSTEM
HEALTH CARE FACILITIES

(NFPA 101A, "Guide on Alternative Approaches to Life Safety" 2013 Edition)

Complete the following worksheets for each fire/smoke zone*.
Where conditions are the same in several zones, one set of worksheets can be used for those zones.
* Fire/smoke zone is a space separated from all other spaces by floors, horizontal exits, or smoke barriers

Step 1 — Complete Cover Sheet using Worksheet 4.7.1.

WORKSHEET 4.7.1 – COVER SHEET

ZONE 2 OF 3 ZONES

NAME OF FACILITY	ADDRESS OF FACILITY		
Southside Care Center	2644 Aldrich Ave. S, Minneapolis, MN 55408		
ZONE(S) EVALUATED			
First Floor			
PROVIDER/VENDOR NO.	DATE OF SURVEY		
24E507	12/16/2019		
SURVEYOR SIGNATURE	TITLE	OFFICE	DATE
Robert S. Lindstrom	President	Fire Safety Resources, LLC	12/31/2019
SURVEYOR ID			
FIRE AUTHORITY SIGNATURE	TITLE	OFFICE	DATE
[signature] 12/24	Fire Safety Supervisor	MN State Fire Marshal	01-14-2020

ADDITIONAL COMMENTS:

CMS FORMS SHALL BE COMPLETED AND RETAINED AS PART OF THE SURVEY RECORD.

Step 2 — Determine Occupancy Risk Parameter Factors using Worksheet 4.7.2.
For each Risk Parameter in Worksheet 7.2, select and circle the appropriate risk factor value.
Choose only one for each of the five Risk Parameters.

WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

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

*A risk factor of 4.0 is charged to any zone that houses patients without any staff in immediate attendance.

Step 3 — Compute Occupancy Risk Factor (F) using Worksheet 4.7.3.
(1) Transfer the circled risk factor values from Worksheet 4.7.2 to the corresponding blocks in Worksheet 4.7.3.
(2) Compute F by multiplying the risk factor values as indicated in Worksheet 4.7.3.

WORKSHEET 4.7.3 - OCCUPANCY RISK FACTOR CALCULATION

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

Step 4 — Compute Adjusted Building Status (R) - Use Worksheets 4.7.4 or 4.7.5.
(1) If building is classified as "NEW" use Worksheet 4.7.4. If building is classified as "Existing" use Worksheet 4.7.5.
(2) Transfer the value of F from Worksheet 4.7.3 to Worksheets 4.7.4 or 4.7.5, as appropriate. Calculate R.
(3) Transfer R to the block labeled R in Worksheet 4.7.9.
(4) In Worksheets 4.7.4 and 4.7.5, results are always rounded up (i.e., 3.2 is rounded to 4.0).

WORKSHEET 4.7.4 ADJUSTED OCCUPANCY RISK FACTOR (NEW)

	F		R
1.0 X		=	

WORKSHEET 4.7.5 ADJUSTED OCCUPANCY RISK FACTOR (EXISTING)

	F		R	
0.6 X	12.7	=	7.6	= 8

Step 5 — Determine Safety Parameter Values using Worksheet 4.7.6.

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

WORKSHEET 4.7.6 – SAFETY PARAMETER VALUES

Safety Parameters	Parameters Values						
1. Construction	Combustible Types III, IV, and V				Non-Combustible Types I and II		
Floor or Zone	000	111	200	211, 2HH	000	111	222, 322, 442
First	(-2)	0	-2	0	0	2	2
Second	-7	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A				
	-5(0)[f]	0(3)[f]	(3)				
3. Interior Finish (Rooms)	Class C	Class B	Class A				
	-3(1)[f]	1(3)[f]	(3)				
4. Corridor Partitions/Walls	None or Incomplete	<1/2 hour	>1/2 to <1 hour		≥1 hour		
	-10(0)[a]	0	(1)(0)[a]		2(0)[a]		
5. Doors to Corridor	No Door	<20 min FPR	≥ 20 min FPR		≥ 20 min FPR and Auto Closure		
	-10	0	(1)(0)[d]		2(0)[d]		
6. Zone Dimensions	Dead End			No Dead Ends >30 ft. and Zone Length Is			
	>100 ft.	>50 ft. to 100 ft.	30 ft. to 50 ft.	>150 ft.	100 ft. to 150 ft.	<100 ft.	
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c] (0)[h]	0(0)[h]	1	
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resistance				
			<1 hr.	≥1 hr. to <2 hr.	≥2 hr.		
	-14	-10	(0)	2(0)[e]	3(0)[e]		
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies		
	In Zone	Outside Zone	In Zone	In Adjacent Zone			
	-11	-5	-6	-2	(0)		
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mechanically Assisted Systems by Zone				
	-5(0)[c]	0	3				
10. Emergency Movement Routes	<2 Routes	Multiple Routes			Direct Exit(s)		
	(-8)	Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)			
		-2	0	1	5		
11. Manual Fire Alarm	No Manual Fire Alarm	Manual Fire Alarm					
		W/O F.D. Conn.	W/F.D. Conn.				
	-4	1	(2)				
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces in Zone		
	0(3)[g]	2(3)[g]	3(3)[g]	(4)	5		
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building				
	0	8	(10)				

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

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

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

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

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200").
For SI Units: 1 ft.² = 0.3048 m²

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

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

[h] Use (0) where zone area ≤ 22,500 ft.² and distance from any point to reach a door in smoke barrier is ≤ 200 ft.

Step 6 — Compute Individual Safety Evaluations using Worksheet 4.7.7.

(1) Transfer each of the 13 circled Safety Parameter Values from Worksheet 4.7.6 to every unshaded block in the line with the corresponding Safety Parameter in Worksheet 4.7.7. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Worksheet 4.7.7 as 1/2 the corresponding value circled in Worksheet 4.7.6.

(2) Add the four columns, keeping in mind that any negative numbers deduct.

(3) Transfer the resulting total values for S1, S2, S3, S4 to blocks labeled S1, S2, S3, S4 in Worksheet 4.7.9 on page 4 of this sheet.

WORKSHEET 4.7.7 - INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-2	-2		-2
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions and 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		4	4	4
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 16	S_2= 14	S_3= 5	S_4= 14

Step 7 — Determine Mandatory Safety Requirement values using Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(1) Using the facility type (i.e., Hospital or Nursing Home), classification (i.e., New, Existing or Rehabilitated) and the floor where the zone is located, circle the appropriate value in each of the three columns found in Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(2) Transfer the three circled values to the blocks marked S_a, S_b, and S_c in Worksheet 4.7.9.

(3) The Mandatory Safety Requirement value for basements are based on the distance of the basement level from the closest level of discharge (See 4.6.1.2 and 4.6.1.3).

WORKSHEET 4.7.8A - MANDATORY SAFETY REQUIREMENTS – NEW HOSPITALS, EXISTING HOSPITALS OR NEW NURSING HOMES

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Existing	New	Existing	New	Existing
1st story	11	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher, but not high rise	18	9	19(16)[a]	6	11(8)[a]	3
High rise	18	17	19(16)[a]	16	11(8)[a]	7

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

b. For a 2nd story zone location in a sprinklered EXISTING hospital, 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: Sa=7, Sb=10, and Sc=7

WORKSHEET 4.7.8B - MANDATORY SAFETY REQUIREMENTS – EXISTING NURSING HOMES

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	(0)	(10)	(0)
2nd story	2	10	2
3rd story	6	14	2
4th story or higher	8	16	2

WORKSHEET 4.7.8C - MANDATORY SAFETY REQUIREMENTS – MAJOR REHABILITATION IN NONSPRINKLERED EXISTING HOSPITALS

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	13	17(14)*	8(5)*
2nd or 3rd story	17	19(16)*	10(7)*
4th story or higher	18	19(16)*	11(8)*

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

Step 8 — Identify Zone Fire Safety Equivalency using Worksheet 4.7.9.

(1) Transfer the three circled values from Worksheet 4.7.8A, 4.7.8B, or 4.7.8C to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.

(2) 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.

WORKSHET 4.7.9 - ZONE FIRE SAFETY EQUIVALENCY EVALUATION

						YES	NO
Containment Safety (S_1)	minus	Mandatory Containment (Sa)	≥ 0	S_1 16 — S_a 0 = C 16		√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (Sb)	≥ 0	S_2 14 — S_b 10 = E 4		√	
People Movement Safety (S_3)	minus	Mandatory People Movement (Sc)	≥0	S_3 5 — S_c 0 = P 5		√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 14 — R 8 = G 6		√	

Step 9 — Evaluate other considerations not previously addressed using Worksheet 4.7.10.
Complete one copy of this separate worksheet for each facility.
For each consideration, select and mark the appropriate column.

WORKSHEET 4.7.10 FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	√		X
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.	√		X
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	√		X
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.	√		X
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	√		X
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 18.3.5.12 and 19.3.5.12.	√		X
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 19.2.9.1.	√		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			√

Step 10 — Determine the equivalency Conclusion to determine if the level of life safety is at least equivalent to that prescribed by the Life Safety Code using Worksheet 4.7.11.

WORKSHEET 4.7.11- CONCLUSIONS

1. ☒ All of the checks in Worksheet 4.7.9 are in the "Yes" column and all applicable considerations in Worksheet 4.7.10 are marked as "Met". The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

2. ☐ All of the checks in Worksheet 4.7.9 are in the "Yes" column and all considerations in Worksheet 4.7.10 marked as "Not Met" have been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

3. ☐ One or more of the checks on Worksheet 4.7.9 are in the "No" column or any considerations in Worksheet 4.7.10 marked as "Not Met" have NOT been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is not shown by this system to be equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

FIRE SAFETY EVALUATION SYSTEM
HEALTH CARE FACILITIES

(NFPA 101A, "Guide on Alternative Approaches to Life Safety" 2013 Edition)

Complete the following worksheets for each fire/smoke zone*.
Where conditions are the same in several zones, one set of worksheets can be used for those zones.
* Fire/smoke zone is a space separated from all other spaces by floors, horizontal exits, or smoke barriers

Step 1 — Complete Cover Sheet using Worksheet 4.7.1.

WORKSHEET 4.7.1 – COVER SHEET

ZONE 3 OF 3 ZONES

NAME OF FACILITY	ADDRESS OF FACILITY		
Southside Care Center	2644 Aldrich Ave. S, Minneapolis, MN 55408		
ZONE(S) EVALUATED			
Second Floor			
PROVIDER/VENDOR NO.	DATE OF SURVEY		
24E507	12/16/2019		
SURVEYOR SIGNATURE	TITLE	OFFICE	DATE
Robert L. Iriotte	President	Fire Safety Resources, LLC	12/31/2019
SURVEYOR ID			
FIRE AUTHORITY SIGNATURE	TITLE	OFFICE	DATE
[signature] 12/24	Fire Safety Supervisor	MN State Fire Marshal	01-14-2020

ADDITIONAL COMMENTS:

CMS FORMS SHALL BE COMPLETED AND RETAINED AS PART OF THE SURVEY RECORD.

Step 2 — Determine Occupancy Risk Parameter Factors using Worksheet 4.7.2.
For each Risk Parameter in Worksheet 7.2, select and circle the appropriate risk factor value.
Choose only one for each of the five Risk Parameters.

WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

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

*A risk factor of 4.0 is charged to any zone that houses patients without any staff in immediate attendance.

Step 3 — Compute Occupancy Risk Factor (F) using Worksheet 4.7.3.
(1) Transfer the circled risk factor values from Worksheet 4.7.2 to the corresponding blocks in Worksheet 4.7.3.
(2) Compute F by multiplying the risk factor values as indicated in Worksheet 4.7.3.

WORKSHEET 4.7.3 - OCCUPANCY RISK FACTOR CALCULATION

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

Step 4 — Compute Adjusted Building Status (R) - Use Worksheets 4.7.4 or 4.7.5.
(1) If building is classified as "NEW" use Worksheet 4.7.4. If building is classified as "Existing" use Worksheet 4.7.5.
(2) Transfer the value of F from Worksheet 4.7.3 to Worksheets 4.7.4 or 4.7.5, as appropriate. Calculate R.
(3) Transfer R to the block labeled R in Worksheet 4.7.9.
(4) In Worksheets 4.7.4 and 4.7.5, results are always rounded up (i.e., 3.2 is rounded to 4.0).

WORKSHEET 4.7.4 ADJUSTED OCCUPANCY RISK FACTOR (NEW)

		F		R
1.0	X		=	

WORKSHEET 4.7.5 ADJUSTED OCCUPANCY RISK FACTOR (EXISTING)

		F		R	
0.6	X	6.9	=	4.1	= 5

Step 5 — Determine Safety Parameter Values using Worksheet 4.7.6.

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

WORKSHEET 4.7.6 – SAFETY PARAMETER VALUES

Safety Parameters	Parameters Values						
1. Construction	Combustible Types III, IV, and V				Non-Combustible Types I and II		
Floor or Zone	000	111	200	211, 2HH	000	111	222, 322, 442
First	-2	0	-2	0	0	2	2
Second	(-7)	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4

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

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

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

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

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

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

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

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200").
For SI Units: 1 ft.² = 0.3048 m²

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

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

[h] Use (0) where zone area ≤ 22,500 ft.² and distance from any point to reach a door in smoke barrier is ≤ 200 ft.

Step 6 — Compute Individual Safety Evaluations using Worksheet 4.7.7.

(1) Transfer each of the 13 circled Safety Parameter Values from Worksheet 4.7.6 to every unshaded block in the line with the corresponding Safety Parameter in Worksheet 4.7.7. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Worksheet 4.7.7 as 1/2 the corresponding value circled in Worksheet 4.7.6.

(2) Add the four columns, keeping in mind that any negative numbers deduct.

(3) Transfer the resulting total values for S1, S2, S3, S4 to blocks labeled S1, S2, S3, S4 in Worksheet 4.7.9 on page 4 of this sheet.

WORKSHEET 4.7.7 - INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-7	-7		-7
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions and 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		5	5	5
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 10	S_2= 10	S_3= 6	S_4= 9

Step 7 — Determine Mandatory Safety Requirement values using Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(1) Using the facility type (i.e., Hospital or Nursing Home), classification (i.e., New, Existing or Rehabilitated) and the floor where the zone is located, circle the appropriate value in each of the three columns found in Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

(2) Transfer the three circled values to the blocks marked S_a, S_b, and S_c in Worksheet 4.7.9.

(3) The Mandatory Safety Requirement value for basements are based on the distance of the basement level from the closest level of discharge (See 4.6.1.2 and 4.6.1.3).

WORKSHEET 4.7.8A - MANDATORY SAFETY REQUIREMENTS – NEW HOSPITALS, EXISTING HOSPITALS OR NEW NURSING HOMES

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Existing	New	Existing	New	Existing
1st story	11	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher, but not high rise	18	9	19(16)[a]	6	11(8)[a]	3
High rise	18	17	19(16)[a]	16	11(8)[a]	7

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

b. For a 2nd story zone location in a sprinklered EXISTING hospital, 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: Sa=7, Sb=10, and Sc=7

WORKSHEET 4.7.8B - MANDATORY SAFETY REQUIREMENTS – EXISTING NURSING HOMES

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	0	10	0
2nd story	(2)	(10)	(2)
3rd story	6	14	2
4th story or higher	8	16	2

WORKSHEET 4.7.8C - MANDATORY SAFETY REQUIREMENTS – MAJOR REHABILITATION IN NONSPRINKLERED EXISTING HOSPITALS

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1st story	13	17(14)*	8(5)*
2nd or 3rd story	17	19(16)*	10(7)*
4th story or higher	18	19(16)*	11(8)*

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

Step 8 — Identify Zone Fire Safety Equivalency using Worksheet 4.7.9.

(1) Transfer the three circled values from Worksheet 4.7.8A, 4.7.8B, or 4.7.8C to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.

(2) 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.

WORKSHET 4.7.9 - ZONE FIRE SAFETY EQUIVALENCY EVALUATION

						YES	NO
Containment Safety (S_1)	minus	Mandatory Containment (Sa)	≥ 0	S_1 10 — S_a 2 = C 8		√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (Sb)	≥ 0	S_2 10 — S_b 10 = E 0		√	
People Movement Safety (S_3)	minus	Mandatory People Movement (Sc)	≥0	S_3 6 — S_c 2 = P 4		√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 9 — R 5 = G 4		√	

Step 9 — Evaluate other considerations not previously addressed using Worksheet 4.7.10.
Complete one copy of this separate worksheet for each facility.
For each consideration, select and mark the appropriate column.

WORKSHEET 4.7.10 FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	√		X
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.	√		X
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	√		X
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.	√		X
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	√		X
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 18.3.5.12 and 19.3.5.12.	√		X
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 19.2.9.1.	√		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			√

Step 10 — Determine the equivalency Conclusion to determine if the level of life safety is at least equivalent to that prescribed by the Life Safety Code using Worksheet 4.7.11.

WORKSHEET 4.7.11- CONCLUSIONS

1. ☒ All of the checks in Worksheet 4.7.9 are in the "Yes" column and all applicable considerations in Worksheet 4.7.10 are marked as "Met". The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

2. ☐ All of the checks in Worksheet 4.7.9 are in the "Yes" column and all considerations in Worksheet 4.7.10 marked as "Not Met" have been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is at least equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

3. ☐ One or more of the checks on Worksheet 4.7.9 are in the "No" column or any considerations in Worksheet 4.7.10 marked as "Not Met" have NOT been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is not shown by this system to be equivalent to that prescribed by NFPA 101, *Life Safety Code*, for health care occupancies.

Report of Consultant FSES Findings

Southside Care Center

2644 Aldrich Avenue South

Minneapolis, MN 55408

Provider No. 24E507

Date of Survey: December 16, 2019

Prepared by:
Robert L. Imholte, President
Fire Safety Resources, LLC
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Mr. Donald Flack
Administrator
Southside Care Center
2644 Aldrich Avenue South
Minneapolis, Minnesota 55408

December 31, 2019

RE: FSES at Southside Care Center

Dear Mr. Flack:

Enclosed please find the survey information relating to the fire safety evaluation of Southside Care Center, 2644 Aldrich Avenue South in Minneapolis, MN, conducted on 12/16/2019. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(2013), *Guide on Alternative Approaches to Life Safety*.

As you're aware, the FSES is a rating system designed to evaluate the level of fire/life safety in health care facilities and serves as a method to demonstrate alternative compliance with the 2012 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 10/30/2018 relating to:

- Construction type and height (K161),
- Exit stairway width (K225),
- First Floor corridor width (K232), and
- Exit stairway enclosure construction (K311).

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 12/16/2019 FSES evaluation, all four parameters in FSES Worksheet 4.7.9, ZONE FIRE SAFETY EQUIVALENCY EVALUATION, in all three zones evaluated were found to have a score of zero or greater. *Fire Safety Resources* finds, therefore, that Southside Care Center has achieved a passing FSES score.

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

Wishing you a safe day!

Robert L. Imholte,
President
Fire Safety Resources, LLC

Enclosures
RLI/rli

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: 15

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

What follows is a report on the results of a fire safety evaluation of the above-named facility that was conducted during an on-site visit to the facility between 1200 hours and 1450 hours on 12/16/2019. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(13), *Guide on Alternative Approaches to Life Safety*. Based on this evaluation, Southside Care Center has achieved a passing score on the FSES.

In addition to observations made and documentation review conducted during the 12/16/2019 on-site visit, the findings outlined herein are based on:

- Information provided by Mr. Donald Flack, Administrator; Mr. Emmanuel Tandoh, Program Director; and Mr. Mike Kelly, Maintenance; and
- A review of the Statement of Deficiencies (Form CMS-2567) from a state agency fire/life safety recertification survey conducted on 12/04/2019.

Initial Comments:
The building housing Southside Care Center was constructed in 1909. Because the building was constructed prior to 07/05/2016, Southside Care Center is considered an existing building for federal certification purposes. The facility was, therefore, treated as such for assigning values on the FSES worksheets.

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. As a result, for purposes of this FSES, Southside Care Center was assigned a Type V(000) construction type in accordance with NFPA 220(12), Sec. 4.6 and Table 4.1.1.

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 Worksheet 4.7.10, 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. There are system-connected automatic smoke detectors on all three levels of the building. Based on interview of the Program Director and documentation review, the fire alarm system is being inspected, tested and maintained in accordance with NFPA 72.

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

This report is intended to serve as an explanation of how the scores entered on FSES Worksheets 4.7.2, 4.7.6 and 4.7.10 (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 Worksheet 4.7.5 (i.e. value of "R") was rounded up to the nearest whole number. Code references are provided where appropriate. Codes referenced include the 2013 edition of NFPA 101A and the 2012 edition of the *Life Safety Code*® (NFPA 101).

All Levels – WORKSHEET 4.7.10. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

In accordance with NFPA 101A(13), Sec. 4.7.9, Step 9, 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 Worksheet 4.7.10 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(12), Sections 9.1 and 9.2.
- No space heaters or incinerator were found.
- The facility's evacuation plan and fire drill records were reviewed and appeared to be in order.
- The facility's smoking regulations were reviewed and appeared to be in order. 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(12), Sec. 19.7.5.
- Portable fire extinguishers, EXIT signage and emergency lighting appeared to be provided and maintained in accordance with applicable requirements.

Zone 1 – Basement Level:

WORKSHEET 4.7.2. OCCUPANY RISK PARAMETER FACTORS

According to information provided by the Program Director, 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(13), Sec. 4.3.2(4)a, only Item 3, Zone Location (*L*), of Worksheet 4.7.2 was addressed and the value of factor *F* in Worksheet 4.7.3, OCCUPANCY RISK FACTOR CALCULATION, was assigned a factor of 1.6 (i.e. the value assigned to basements in factor *L* of Worksheet 4.7.2).

WORKSHEET 4.7.6. 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 Worksheet. 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(12), 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 and smoke-separated as required by NFPA 101A(13), Sec. 4.6.8.2.
9. Smoke Control [Score: 0]:
   This score was assigned per Footnote c to this Worksheet 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(12), Sec. 19.2.4.2.
    - 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(12), Sec. 7.1.5.3.
    - The stairway from the basement was found to be only 30 inches in clear width instead of the 36 inches required by NFPA 101(12), Sec. 7.2.2.2.1.1(2) and Table 7.2.2.2.1.1(b).
    - The stairway from the basement was found to have winder-type treads, which are not allowed by NFPA 101(12), Sections 19.2.2.3 and 7.2.2.2.4.1.
    - 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: +5]:
    The zone was found to be protected by automatic smoke detector coverage of all spaces in the zone as specified in NFPA 101A(13), Sec. 4.6.12.5. This Parameter, therefore, was scored as "Total Spaces in Zone".
13. Automatic Sprinklers [Score: +10]:
    The building is protected by a supervised, wet-pipe automatic fire sprinkler system consisting of quick-response sprinklers.

<u>Zone 2 – First Floor</u>:

WORKSHEET 4.7.2. OCCUPANY 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. However, previous FSES evaluations revealed that the facility will at times admit residents in this zone who move at a slower rate of travel (e.g. use a cane). Review of the facility's admission policy and interview of the Program Director confirmed that the facility will only admit residents who are ambulatory and capable of exiting the facility without staff assistance. A review of the facility's Form CMS-672, dated 10/12/2019, revealed that all residents are classified as "Independently ambulatory".
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". The facility accepts residents who are age 65 years and over.

WORKSHEET 4.7.6. 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(13), 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 Worksheet. 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(12), 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 Worksheet (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(12), Sections 19.2.5.4 and 7.5.2.1;
    - 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(12), Sec. 7.2.1.4.2(2). In addition, the door to the exterior from this enclosure is only 30 inches in clear width;
    - The stairway from the 1st 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(2013), Sec. 4.6.10.3.2];
    - While the east (front) corridor measures 43 inches in clear width, the west (back) corridor was found to narrow to 33 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 NFPA 101(12), Sec. 19.2.3.7(2) (the facility's fire plan does not require evacuation by bed, gurney or wheelchair), NFPA 101A(13), 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

10. Emergency Movement Routes (continued)
    - 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(12), 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: +4]:
    The zone was found to be protected by automatic smoke detectors installed in the corridors and habitable spaces as specified in NFPA 101A(13), Sec. 4.6.12.4.
13. Automatic Sprinklers [Score: +10]:
    The building is protected by a supervised, wet-pipe automatic fire sprinkler system consisting of quick-response sprinklers.

Zone 3 – Second Floor:

WORKSHEET 4.7.2. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 1.0]: It was reported that all residents housed in this zone are capable of removing themselves from danger exclusively by their own efforts. A review of the facility's admission policy and interview of the Program Director confirmed that the facility will only admit residents who are ambulatory and capable of exiting the facility without staff assistance. A review of the facility's Form CMS-672, dated 10/12/2019, revealed that all residents are classified as "Independently ambulatory".
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". The facility accepts residents who are age 65 years and over.

WORKSHEET 4.7.6. 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(13), 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(13), 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 Worksheet. 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(12), 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 Worksheet (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(12), 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 1st Floor, and, therefore, could not be credited as an egress route [see NFPA 101A(13), 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(12), Sec. 7.2.1.4.2(2);
    - 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(12), Sec. 7.1.5.3; and
    - Resident room doors were found to measure between 29 and 30 inches in clear width. While the door width meets the requirements of NFPA 101(12), Sec. 19.2.3.7(2) (the facility's fire plan does not require evacuation by bed, gurney or wheelchair), NFPA 101A(13), 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 NFPA 101(12), Sec. 19.3.4.2.2. The fire alarm system is monitored by Wright-Hennepin (WH) Response.
12. Smoke Detection and Alarm [Score: +5]:
    The zone was found to be protected by automatic smoke detector coverage of all spaces in the zone as specified in NFPA 101A(13), Sec. 4.6.12.5. This Parameter, therefore, was scored as "Total Spaces in Zone".
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 1200 hours and 1450 hours on 12/16/2019. 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*.

Electronically delivered
December 30, 2019

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

Re: State Nursing Home Licensing Orders
Event ID: XCVS11

Dear Administrator:

The above facility was surveyed on December 2, 2019 through December 4, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. 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 or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

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.

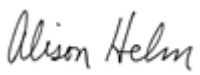
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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:

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (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.



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

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	00780	A. BUILDING: _____ B. WING _____	C 12/04/2019

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

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3 000	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME LICENSING CORRECTION ORDER 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. 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. 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. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are	3 000		

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3 000	Continued From page 1 delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 12/2/19 through 12/4/19, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. In addition, the following complaint was found to be substantiated and licensing orders were issued.	3 000		
3 601	MN St. Statute 144.56 Subp. 2c Tuberculosis Prevention And Control (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	3 601		1/18/20

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3 601	Continued From page 2 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. (b) Written compliance with this subdivision must be maintained by the boarding care home. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure the required baseline tuberculosis (TB) screening was completed and results accurately documented for 3 of 6 employees (C-A, RN-A, LPN-A) per current Center for Disease Control and Prevention (CDC) recommendations and facility policy. This had the potential to affect all residents residing in the facility and employed staff. Additionally, the facility failed to ensure annual TB training for 2 of 9 (RN-B, C-A) employees was completed. Findings include: A Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH dated 6/12/19, indicated all employees would have baseline TB screening performed at the time of hire and would have completed annual TB screening. Cook (C)-A date of hire 7/25/18, had the first-step	3 601	3601 Tuberculosis Prevention and Control a. The facility will verify that all paid employees, unpaid employees, contractors, students, residents, and volunteers will have a verified 2-step tuberculosis test that is up to date including the identified staff: Registered nurse RN-A date of hire 5/29/18, LPN-A date of hire 1/1997, and C-A date of hire 7/25/18, have up to date 2-step tuberculosis tests and are educated on the 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). b. All paid employees, unpaid employees, contractors, students, residents, and volunteers will have	

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3 601	Continued From page 3 tuberculin skin test (TST) on 7/9/19, which was not read. C-A had the second-step TST on 7/24/19 which was read on 7/27/19 as negative. Registered nurse (RN)-A date of hire 5/29/18, indicated positive responses on the symptom screen dated 7/8/19, to having been born outside the U.S., previous positive reaction to a TST, and received the BacillusCalmette-Guerin (BCG). RN-A received the first-step TST on 7/8/19, and it was read on 7/10/19, as negative. RN-A lacked evidence of a second-step TST. LPN-A date of hire 1/1997, had the first-step TST on 7/8/19, which was read as negative on 7/10/19. LPN-A had a second-step TST on 7/24/19, which was not read. C-A date of hire 7/25/18, lacked evidence in the employee file of annual TB training. RN-B date of hire 2/10/18, lacked evidence of annual TB training in the employee file. RN-C was interviewed on 12/4/19, at 11:23 a.m. and verified the second step TST had not been completed for RN-A and TST was not read for C-A and LPN-A. RN-C stated it was her expectation for all employees to have had a two step TST testing and to have had all employees complete annual TB education. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise the current TB policies and procedures to ensure all employees are screened for physical signs and symptoms of active TB disease and provided the TB testing as recommended by State regulation. The DON or	3 601	verified 2 – step tuberculosis test that is up to date and maintained by the nursing department at Southside Care Center. Additionally, all staff will be trained on the 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). c. The policy and procedure at Southside Care Center will be updated, reviewed, and maintained for a 2-step Tuberculosis test for all paid employees, unpaid employees, contractors, students, residents, and volunteers and 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). All staff in the facility will be educated on this policy. d. The administrator or designee will conduct a minimum of quarterly audits that all paid employees, unpaid employees, contractors, students, residents, and volunteers have up to date 2-step tuberculosis tests and that a comprehensive tuberculosis infection control program remains current to CDC recommended guidelines. The frequency of the audits will be modified and adjusted as needed depending on the results and discussed in the quarterly Quality Assurance meetings.	

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3 601	Continued From page 4 designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	3 601		
3 945	MN Rule 4655.6400 Subp. 1 Adequate Care; Care in General Subpart 1. Care in general. Each patient or resident shall receive nursing care or personal and custodial care and supervision based on individual needs. Patients and residents shall be encouraged to be active, to develop techniques for self-help, and to develop hobbies and interests. Nursing home patients shall be up and out of bed as much as possible unless the attending physician states in writing on the patient ' s medical record that the patient must remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to investigate causal factors related to falls and comprehensively reassess and implement additional fall interventions for 1 of 2 residents (R165) reviewed for falls. Findings include: R165's quarterly Minimum Data Set (MDS) dated 8/25/19, identified R165 had intact cognition and	3 945	Please refer to the plan of correction written and submitted for F689 Free of Accident Hazards/Supervision/Devices	1/18/20

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3 945	Continued From page 5 diagnoses which included schizophrenia and depression. The MDS indicated R165 was independent with transfers and mobility. The MDS indicated R165 had no past history of falls. R165's Falls Care Area Assessment dated 6/5/19, identified R165 was at risk for falls and directed staff to monitor medication side effects, complete fall risk assessment, monitor for changes and continue current fall interventions. R165's care plan dated 9/23/19, identified R165 was at risk for falls and fell on 9/14/19, and 9/23/19, and directed staff to anticipate and meet needs, ensure call light was within reach and encourage use, staff to ensure prompt response to all request for assistance, encourage participation in activities that promoted exercise, physical activity for strengthening and improved mobility, ensure appropriate footwear was worn, therapy evaluate and treat as ordered, ensure safe environment with even floors, free from spills and/ or clutter, adequate light, bed in low position at night personal items within reach, remind to wear light sandals and lift feet. However, R165's care plan lacked evidence of evaluation regarding current risks and interventions following 10/2/19, fall which resulted in right humerus fracture. R165's Fall Risk Evaluation dated 9/29/19, identified R165 was a score of 18 which indicated high falls risk. However, the evaluation lacked evidence of identified interventions to decrease R165's risk for falls and evaluation following R165's fall with right humerus fracture. R165's Fall/ Presumed Fall Incident Report and Interdisciplinary Notes (IN) were reviewed	3 945		

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3 945	Continued From page 6 9/14/19, through 11/26/19, and revealed the following: -The report dated 9/14/19, indicated R165 was "rushing" to the bathroom slipped and landed on buttocks due to having had bare feet. Staff to remind R165 to wear non-skid socks or shoes at all times; -The report dated 9/23/19, indicated R165 was wearing sandals and observed dragging her feet causing R165 to fall on way to the bathroom staff were to replace shoes and remind R165 to lift feet when walking; -The report dated 10/2/19, indicated R165 fell and the causal factor was "not known exactly" care plan would be updated when R165 returned from "rehab;" -The IN dated 10/2/19, indicated R165 fell when in the dining room and reported R165 hit the table and landed on her right hand and shoulder fracture was suspected and paramedics were called and transported R165 to the hospital. A subsequent IN dated 10/2/19, indicated hospital called and confirmed R165 had humerus fracture. An additional IN dated 10/2/19, indicated the facility requested R165 be sent to "rehab" prior to return to the facility due to incontinence, not very steady walking, always holding onto things while walking which include tables; -The IN dated 11/26/19, indicated R165 was readmitted to the facility and now used a walker for ambulation further assessment to have been done. R165's medical record lacked evidence of causal factor following 10/2/19, fall with right humerus fracture evaluation of current interventions and development of immediate interventions.	3 945		

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3 945	Continued From page 7 R165 was observed on 12/2/19, at 1:33 p.m. seated in the dining room then stood up pushed left hand off of table and right hand off of chair R165 moved her walker to the side and held onto the door frame and walked into the bathroom without assistance. R165 was wearing black slippers and had a shuffled gait. R165 was interviewed on 12/2/19, at 5:34 p.m. and stated she did not remember falling and fracturing her humerus. Housekeeper (HSK)-A was interviewed via telephone on 12/3/19, at 11:33 a.m. and confirmed he was in the room when R165 fell on 10/2/19. HSK-A explained when R165 stood up from the chair and began walking she lost her balance and tried to hold onto the table however, R165 was unable to steady self and fell down onto the floor. Licensed practical nurse (LPN)-A was interviewed on 12/3/19, at 2:52 p.m. and stated R165 "sometimes" used her walker and "sometimes she doesn't." LPN-A stated prior to R165's fall on 10/2/19, she would hold onto the rails, furniture and other items when walking. LPN-A indicated he had been "watching her" since she came back and noted no concerns with R165 walking. The administrator and LPN-A were interviewed on 12/3/19, at 5:10 p.m. The administrator confirmed R165's care plan and fall risk assessment had not been updated since R165's fall on 10/2/19, and/ or return to facility following rehabilitation stay on 11/26/19. The administrator stated it was his expectation for R165's fall risk and care plan to have been updated upon R165's	3 945		

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3 945	Continued From page 8 return to the facility. Registered nurse (RN)-C was interviewed on 12/4/19, at 9:08 a.m. and stated she was present when R165 fell on 10/2/19. RN-C indicated R165 stood up from the chair with a cup of coffee in her hand and lost her balance as she attempted to reach something on the table, however RN-C indicated there was nothing on the table at the time of R165's fall. RN-C stated R165 attempted to lean on the table lost her balance and fell to the floor landing on her right side and began crying due to pain and would not allow staff to touch her. RN-C indicated R165 was transferred to the hospital. The facility Falls Prevention and Management Program dated 5/30/18, indicated the fall risk assessment should have been completed within 24 hours of admission, quarterly, when a change in health status puts them at increased risk for falling such as a fall resulting in serious injury which included fractures and any injury requiring assessment in emergency room and/ or admission to the hospital. The policy indicated monitor and evaluate the care plan at least quarterly and if the interventions were not effective in reducing falls, initiate alternative approaches and update as necessary. The policy indicated post fall assessment would include "redo" fall risk assessment, review the fall prevention interventions and modify the care plan. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review, revise policies and procedures regarding comprehensive assessment and interventions related to falls.	3 945		

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3 945	Continued From page 9 Facility staff could be educated on these policies and procedures. The administrator, DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	3 945		
31925	MN Rule 144.651 Subd. 29 Patients & Residents of HCF Bill of Rights Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident ' s right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This MN Requirement is not met as evidenced by:	31925		1/18/20

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31925	Continued From page 10 Based on interview and document review, the facility failed to provide written hospital transfer notices to the resident(s) and/or resident's representative who had a facility initiated transfer and failed to accurately notify the Office of the State Long-Term Care Ombudsman (OMB) of hospital transfers for 1 of 1 resident (R165) reviewed for hospitalizations. Findings include: The administrator was interviewed on 12/2/19, at 6:20 p.m. and stated he did not think the facility notified the OMB when R165 was hospitalized in October 2019. R165's Progress Note (PN) dated 10/2/19, indicated R165 fell and was sent to the hospital due to pain in her shoulder. A subsequent PN dated 10/2/19, indicated the facility called the hospital and requested to send R165 to "rehab first" prior to returning to facility. R165's medical record lacked evidence of notification and/or reason regarding transfer, the statement of the residents' appeal rights or information on how an appeal form was obtained, and it lacked the contact information of the Office of the States Long-Term Care Ombudsman. The OMB was interviewed on 12/3/19, at 1:38 p.m. and stated she did not receive any notice of transfer and discharge for R165 during the previous six months. Licensed practical nurse (LPN)-A was interviewed on 12/3/19, at 3:36 p.m. and stated the facility would call to notify the OMB when someone discharged. LPN-A verified they did not	31925	Please refer to the plan of correction submitted for both F623 Notice Requirements Before Transfer/Discharge and F625 Notice of Bed Hold Policy Before or Upon Transfer	

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31925	Continued From page 11 have a notice of transfer and discharge process when sending a resident to the hospital. The facility policy regarding transfer of a resident to the hospital was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review, revise policies and procedures regarding notice before transfer. Facility staff could be educated on these policies and procedures. The administrator or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	31925		