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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: A1VZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00160

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245520**
2.STATE VENDOR OR MEDICAID NO.
(L2) **599340700**

3. NAME AND ADDRESS OF FACILITY
(L3) **REDEEMER RESIDENCE INC**
(L4) **625 WEST 31ST STREET**
(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 **01/19/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (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)
12/31

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

12.Total Facility Beds **119** (L18)
13.Total Certified Beds **119** (L17)

10.THE FACILITY IS CERTIFIED AS:
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
	119			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Lisa Hakanson, HFE NEII 01/31/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/13/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/19/2017
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5520

On January 19, 2017 and January 24, 2017, the Departments of Health and Public Safety completed revisits to verify correction of deficiencies issued pursuant to the December 1, 2016 survey. Based on our revisits, we have determined the facility corrected all deficiencies, effective January 10, 2017

In addition, at the time of the revisit, complaint number H5520059 that was found to be substantiated at F431, was verified and found corrected.

Refer to the CMS 2567b forms for the results of the health and life safety code visits.

Effective January 10, 2017, the facility is certified for 119 skilled nursing facility beds.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245520

April 6, 2017

Mr. Danny Colgan, Administrator
Redeemer Residence Inc
625 West 31st Street
Minneapolis, Minnesota 55408

Dear Mr. Colgan:

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

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

Effective January 10, 2017 the above facility is certified for:

129 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 129 skilled nursing facility beds.

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 31, 2017

Mr. Danny Colgan, Administrator
Redeemer Residence Inc
625 West 31st Street
Minneapolis, Minnesota 55408

RE: Project Number S5520027, H5520059

Dear Mr. Colgan:

On December 19, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 1, 2016 and to investigate complaint number H5520059, which was found substantiated at F431. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On January 19, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on January 24, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 1, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 10, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 1, 2016, effective January 10, 2017 and therefore remedies outlined in our letter to you dated December 19, 2016, will not be imposed.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245520 Y1	A. Building B. Wing Y2	1/19/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET MINNEAPOLIS, MN 55408

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0156	Correction	ID Prefix	F0282	Correction	ID Prefix	F0314	Correction
Reg. #	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18)	Completed	Reg. #	483.21(b)(3)(ii)	Completed	Reg. #	483.25(b)(1)	Completed
LSC		01/10/2017	LSC		01/10/2017	LSC		01/10/2017
ID Prefix	F0329	Correction	ID Prefix	F0371	Correction	ID Prefix	F0428	Correction
Reg. #	483.45(d)(e)(1)-(2)	Completed	Reg. #	483.60(i)(1)-(3)	Completed	Reg. #	483.45(c)(1)(3)-(5)	Completed
LSC		01/10/2017	LSC		01/10/2017	LSC		01/10/2017
ID Prefix	F0431	Correction	ID Prefix	F0514	Correction	ID Prefix		Correction
Reg. #	483.45(b)(2)(3)(g)(h)	Completed	Reg. #	483.70(i)(1)(5)	Completed	Reg. #		Completed
LSC		01/10/2017	LSC		01/10/2017	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	KS/mm	04/11/2017	28230	01/19/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 12/1/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245520 Y1	A. Building 01 - BUILDING 01 B. Wing Y2	1/24/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET MINNEAPOLIS, MN 55408

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0353	12/23/2016	LSC	K0541	01/10/2017	LSC	K0741	01/10/2017
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0918	01/10/2017	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
X	TL/mm	01/31/2017	37009	01/24/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
11/29/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 11, 2017

Mr. Dan Colgan, Administrator
Redeemer Residence Inc.
625 West 31st Street
Minneapolis, Minnesota 55408

Subject: Redeemer Residence Inc - Independent Dispute Resolution (IDR)
CMS Certification Number (CCN): 24 5520
Project Number: S5520027

Dear Mr. Colgan:

This is in response to your letter of December 28, 2016, in regard to your request for an informal dispute resolution (IDR) for the federal deficiencies at tags F225 and F226 issued pursuant to the survey event A1VZ11, completed on December 1, 2016.

The information presented with your letter, the CMS 2567 dated December 1, 2016 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F225 S/S-D 42 CFR § 483.12 (a) (3) (4) (c) (1)-(4) Investigate/Report Allegations/Individuals

F226 S/S-D 42 CFR §483.12 (b) (1)-(3), 483.95 (c) (1)-(3) Develop/Implement Abuse/Neglect, Policies

Summary of the facility's reason for IDR of this tag:
The facility disputed the findings at F225 and F226 based on the fact that staff including the licensed social worker, RN-B, RN-C, the director of nursing and administrator had never been notified of any alleged verbal abuse by R110 nor R139 prior to interview with the surveyor. The facility asserts upon learning of the alleged verbal abuse, facility staff immediately submitted the reports in a timely manner. Both R110 and R139 later denied actual verbal abuse occurred when interviewed and were unable to verbalize a time, date or which staff had allegedly verbally abused them. In addition, the facility identified R110 had been ill during the time of the surveyor's interview and had been experiencing confusion. The facility further indicated R139 had denied any report of alleged abuse when their staff had interviewed him regarding concerns the State survey team had brought to their attention.

Summary of the facts: Although both R110 and R139 had responded to standardized questions related to "abuse" with a "yes", no further concrete evidence was communicated to indicate whether any alleged abuse had occurred. Neither R110 nor R139 were able to identify any details about their

allegations such as time or dates of occurrence, or any additional information surrounding the alleged incidents of verbal abuse. Although both residents told the surveyor they had reported their allegations to the head nurse, the surveyor had not interviewed the head nurse during the survey to corroborate the resident's comments. In addition, during interview with a number of facility staff, they consistently indicated neither resident had reported any allegations of abuse to them. Once the staff had been informed by the survey team of the residents' allegations, they immediately made a report to the State agency, and initiated an investigation. During facility staff interviews with R110 and R139, as part of the facility's investigation, both residents denied their allegations, changed their comments and could still not report any specifics.

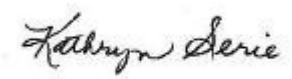
Summary of findings:
After review of the CMS 2567, information submitted by the facility, a phone conference with facility staff, review of MDH surveyor documentation, and discussion with licensing and certification staff, it was determined there was inadequate evidence to verify deficiencies existed related to immediate reporting of abuse allegations. F225 nor F226 do not reflect valid examples of deficient practice and will be removed from the CMS 2567 Statement of Deficiencies.

The revised Statement of Deficiencies is attached.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,



Kathryn M. Serie, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 507-476-4233 Fax: 507-537-7158

cc: Office of Ombudsman for Long-Term Care
Maria King, Assistant Program Manager
Gayle Lantto, Metro D Unit Supervisor
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET MINNEAPOLIS, MN 55408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS REVISED CMS 2567 as a result of the IDR 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 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. At the time of the standard recertification survey a complaint H5520059 was also investigated and was found substantiated at F431.	F 000		
F 156 SS=D	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:	F 156		1/10/17

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

Electronically Signed | 12/29/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 156	Continued From page 1	F 156		

(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -

(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;

(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.

(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 156	Continued From page 2	F 156		

(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)
[§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]

(iii) Information regarding Medicare and Medicaid eligibility and coverage;
[§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;
[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]

(v) Contact information for the Medicaid Fraud Control Unit; and
[§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]

(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 156	Continued From page 3	F 156		

directives requirements and requests for information regarding returning to the community.

(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:

(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and

(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.

(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(g)(16) The facility must provide a notice of rights

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 156	Continued From page 4	F 156		

and services to the resident prior to or upon admission and during the resident's stay.

(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

(g)(17) The facility must--

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 156	Continued From page 5	F 156		

(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.

(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.

(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.

(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.

(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.

v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 156	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide documentation of a two-day notice of denial of Medicare benefits for 1 of 3 residents (R134) whose liability notices were reviewed. Findings include: R134's Census Data Information indicated the resident was admitted to the facility on 9/1/16, and discharged on 9/21/16. The medical record lacked a 2-day notice of discharge from Medicare A. On 11/30/16, at 1:40 p.m. the business office manager verified she was unable to find any documentation R134 was provided the Medicare Provider Non-Coverage form. On 11/30/16, at 3:17 p.m. licensed social worker (LSW)-B stated because the resident was discharged from the facility on her last day of therapy, they were under the impression they did not need to provide the resident with the Medicare Provider Non-Coverage form. LSW-B verified R134 had not received the proper denial notice. On 12/1/16, at 10:07 a.m. the quality assurance coordinator explained they initially did not think they made an error on the denial notice for R134, but stated, "We goofed." The facility was unable to provide documentation R134 had been given a two-day notice Medicare benefits would be ending.	F 156	The Facility submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction is not admission or an agreement that a deficiency exists or that the statement of a deficiency was correctly cited or factually based and it□s also not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same. F156 Notice of Rights, Rules, Services and Charges It is the facility□s practice to follow Medicare guidelines which includes a 2 day notice of denial of Medicare benefits to the resident or responsible party. Social services staff have been re-educated on requirements of denial notices. Random audits will be completed and data reviewed at QAPI meetings. QAPI team to determine duration and frequency of audits based on data obtained through audits. Responsible for compliance: Social Services Director Responsible for overall compliance: Administrator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 156	Continued From page 7 The facility's 11/1/12, Beneficiary Notices policy directed staff to follow Centers for Medicare and Medicaid Services (CMS) regulations for notification of beneficiaries when a Medicare stay would be ending. "The beneficiary is notified using the current version of the CMS required form and is given to the beneficiary at least 2 days prior to the date that the facility has determined to be the last Medicare covered date."	F 156		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to follow the care plan directing every two hours repositioning for 1 of 1 resident (R69) reviewed for pressure ulcers. Findings included: R69's altered skin integrity care plan dated 11/28/16, directed staff to assist the resident every two hours with repositioning. The current nursing assistant (NA) day shift group card directed staff to reposition R69 every two hours in bed and wheelchair. R69 who had bilateral pressure ulcers on the feet was observed continuously 12/1/16 from 8:18	F 282	F282 Services by qualified persons per care plan It is the facility□'s practice and expectation that the care plan interventions for all areas including skin care be followed by all employees at all times unless the resident exercises their right to refuse such interventions. The Care plan was reviewed for R69 and the care plan interventions remain appropriate. Nursing staff have been re-educated on facility practice for need to follow care planning interventions. Random audits of care plan compliance for repositioning will be completed and	1/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 282	Continued From page 8 a.m. until 11:04 a.m. (2 hours, 49 minutes) and was not repositioned according to the care plan. Between 8:18 a.m and 9:00 a.m. R69 was in bed in the supine position. A bed side table was pulled up to the side of the bed, and R69 was covered with bed linen and blanket, and the room was dark. At 9:00 a.m. registered nurse (RN)-B entered with R69's breakfast tray and asked the resident if he wanted to eat. RN-B then raised the head of the bed to approximately 80 degrees. At 9:07 a.m. R69 pushed his call light and yelled for help. At 9:08 a.m. an unidentified person dressed in street clothes spoke to R69 from the doorway. At 9:14 a.m. an (unidentified) nursing assistant answered call light and R69 requested the head of bed be lowered. The nursing assistant (NA) lowered the head of the bed, and took the breakfast tray from the room. From 9:14 a.m. to 10:45 a.m. R69 continued to rest in bed, in the supine position with the room dark and the door half way open. At 10:45 a.m. R69 put the call light on again. R69 informed a NA he wanted to get up for the day. The NA said additional help was needed. At 11:00 a.m. another NA entered the room and explained the NA was obtaining supplies and he would get up soon. R69 continued to yell out and request would someone just get him out of bed. At 11:07 a.m. NA-A entered the room explained he would be helping R69 get up, and then the nurse would complete his multiple treatments. NA-A provided morning cares including incontinence care. R69's incontinence brief was wet with urine. When R69 was rolled onto his left side the buttocks area was very bright red with multiple deep creases. On the coccyx area there was an approximately 2-inch slit with depth and redness noted. R69 had two unstable pressure ulcers on the left foot and	F 282	data reviewed at QAPI meetings. QAPI team to determine duration and frequency of audits based on data obtained through audits. Responsible persons: Nurse Managers Responsible for overall compliance: Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 282	Continued From page 9	F 282		

one scabbed pressure ulcer on the right foot.

R69's electronic medical record (EMR) revealed diagnoses that included right hip postoperative wound infection due to prosthesis, peripheral vascular disease, heart failure, and atrial fibrillation. The annual Minimum Data Set (MDS) dated 8/24/16 indicated R69 had intact cognition and required extensive assistance for all activities of daily living, transferring and repositioning. The Care Area Assessment (CAA) for pressure ulcers indicated the resident was at risk of skin breakdown, however, no pressure ulcers were identified at that time.

A hospital discharge summary revealed R69 was hospitalized from 11/10 through 11/22/16, where he had been treated for a right hip infection, experienced left extremity edema and was using Unna boots bilaterally. Review of progress notes and event charting indicated R69 returned from the hospital on 11/22/16, with the following skin conditions: 1) 6 x 3 centimeter (cm) blister on right medial foot; 2) 2 x 2 cm and 1 x 1 cm stasis ulcer lateral right calf; 3) 2 x 1 pressure ulcer (unstageable/scabbed) lateral right foot; 4) 4 x 3 pressure pressure (unstageable) lateral left foot; and 5) 2 x 2 cm pressure ulcer (unstageable) lateral left heel. Additionally an event was documented on 12/1/16 indicating a 3.2 x 0.1 cm area with superficial depth between the buttocks. The area was described as a moisture-associated skin disorder.

On 12/1/16, at 2:20 p.m. NA-A stated he had offered to reposition R69 before 8:00 a.m. however, R69 had refused assistance at that time, and explained the resident did not like to be positioned on his side.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 282	Continued From page 10 On 12/1/16, at 2:00 p.m. registered nurse (RN)-B confirmed R69 should have been repositioned every two hours according to his care plan.	F 282		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to provided repositioning to minimize the risk of pressure ulcers for 1 of 1 resident (R69) who had existing pressure ulcers. Findings include: R69 who had bilateral pressure ulcers on the feet was observed continuously 12/1/16 from 8:18 a.m. until 11:04 a.m. (2 hours, 49 minutes) and was not repositioned according to the care plan.	F 314	F 314 Treatment/Svcs to prevent/heal pressure sores It is the facility□'s practice to assess a resident'□s skin per facility policies and standards of care. R69 had his skin observed, evaluated, and assessed after his hospital return. On 12/1/2016 when an open area to the coccyx was discovered a facility event was created and the area was assessed by 2 RNs determining the open area was	1/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 314	Continued From page 11 Between 8:18 a.m and 9:00 a.m. R69 was in bed in the supine position. A bed side table was pulled up to the side of the bed, and R69 was covered with bed linen and blanket, and the room was dark. At 9:00 a.m. registered nurse (RN)-B entered with R69's breakfast tray and asked the resident if he wanted to eat. RN-B then raised the head of the bed to approximately 80 degrees. At 9:07 a.m. R69 pushed his call light and yelled for help. At 9:08 a.m. an unidentified person dressed in street clothes spoke to R69 from the doorway. At 9:14 a.m. an (unidentified) nursing assistant answered call light and R69 requested the head of bed be lowered. The nursing assistant (NA) lowered the head of the bed, and took the breakfast tray from the room. From 9:14 a.m. to 10:45 a.m. R69 continued to rest in bed, in the supine position with the room dark and the door half way open. At 10:45 a.m. R69 put the call light on again. R69 informed a NA he wanted to get up for the day. The NA said additional help was needed. At 11:00 a.m. another NA entered the room and explained the NA was obtaining supplies and he would get up soon. R69 continued to yell out and request would someone just get him out of bed. At 11:07 a.m. NA-A entered the room explained he would be helping R69 get up, and then the nurse would complete his multiple treatments. NA-A provided morning cares including incontinence care. R69's incontinence brief was wet with urine. When R69 was rolled onto his left side the buttocks area was very bright red with multiple deep creases. On the coccyx area there was an approximately 2-inch slit with depth and redness noted. A clean brief was applied. The nurse was unavailable to come in at that time to view the area. NA-A removed bilateral fleece-type boots. R69 had two	F 314	moisture related and a result of the resident□s refusal of cares. R69 had his skin assessed by the Nurse Practitioner on December 5, 2016 who indicated the area in question to his coccyx was not pressure related and that the treatment in place was effective and had resolved the open area at that time. Nursing staff have been re-educated on facility requirements for skin documentation with readmissions from the hospital. Random audits will be completed and data reviewed at QAPI meetings. QAPI team to determine duration and frequency of audits based on data obtained through audits. Responsible persons: Nurse Managers Responsible for overall compliance: Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 314	Continued From page 12	F 314		

unstable pressure ulcers on the left foot and one scabbed pressure ulcer on the right foot.

At 11:22 a.m. R69 reported he did not get up in the morning at the time he preferred, but instead "always has to wait for someone."

At 11:29 a.m. licensed practical nurse (LPN)-entered the room to complete R69's treatments. LPN-B applied lotion bilaterally to R69's feet and wrapped them with Kerlix gauze. LPN-B was unable to check the coccyx at the time, but said she was unaware of any skin issues, but would check the resident's skin when he was in bed.

R69's electronic medical record (EMR) revealed diagnoses that included right hip postoperative wound infection due to prosthesis, peripheral vascular disease, heart failure, and atrial fibrillation. The annual Minimum Data Set (MDS) dated 8/24/16 indicated R69 had intact cognition and required extensive assistance for all activities of daily living, transferring and repositioning. The Care Area Assessment (CAA) for pressure ulcers indicated the resident was at risk of skin breakdown, however, no pressure ulcers were identified at that time.

A hospital discharge summary revealed R69 was hospitalized from 11/10 through 11/22/16, where he had been treated for a right hip infection, experienced left extremity edema and was using Unna boots bilaterally. Review of progress notes and event charting indicated R69 returned from the hospital on 11/22/16, with the following skin conditions: 1) 6 x 3 centimeter (cm) blister on right medial foot; 2) 2 x 2 cm and 1 x 1 cm stasis ulcer lateral right calf; 3) 2 x 1 pressure ulcer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 314	Continued From page 13	F 314		

(unstageable/scabbed) lateral right foot; 4) 4 x 3 pressure pressure (unstageable) lateral left foot; and 5) 2 x 2 cm pressure ulcer (unstageable) lateral left heel. Additionally an event was documented on 12/1/16 indicating a 3.2 x 0.1 cm area with superficial depth between the buttocks. The area was described as a moisture-associated skin disorder.

The current NA day shift group card directed staff to reposition R69 every two hours in bed and wheelchair. Although it identified the use of a hip abductor pillow, it did not address the use of specialized protective boots.

R69's altered skin integrity care plan dated 11/28/16, directed staff to assist the resident every two hours with repositioning. Although pressure ulcers were identified on the care plan, the use of protective boots was not included as an intervention.

On 12/1/16, at 2:20 p.m. NA-A stated he had offered to reposition R69 before 8:00 a.m. however, R69 had refused assistance at that time, and explained the resident did not like to be positioned on his side.

On 12/1/16, at 2:00 p.m. registered nurse (RN)-B confirmed R69 should have been repositioned every two hours according to his care plan. RN-B also confirmed the presence of pressure ulcers on R69's feet upon returning from the hospital. RN-B said he was supposed to wear protective footwear and it should have been added to his care plan. Additionally, RN-B was unaware of the observed coccyx wound, but said she would follow up.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	**625 WEST 31ST STREET 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 329	Continued From page 14	F 329		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral	F 329		1/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 329	Continued From page 15 interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete gradual dose reduction (GDR) for psychotropic medication Seroquel for 1 of 5 residents (R47) reviewed for unnecessary medications. Findings include: R47's diagnoses include dementia, anxiety, major depressive disorder, psychotic disorder, history of right cardiovascular accident (CVA) and obsessive compulsive disorder (OCD). R47's 11/1/16, Physician Order Report indicated orders for Seroquel, an antipsychotic, 12.5 milligrams (mg) once daily at bedtime with start date of 8/12/15. R47's physician orders did not show additional attempts at dose reduction for R47's continued use of Seroquel since last dose reduction dated 8/20/15. Additionally, there was no documentation from R47's primary care provider regarding attempt at dose reduction. R47's quarterly Minimum Data Set (MDS) dated 10/19/16, indicated R47 had mild cognitive impairment, experienced delusions and exhibited verbal behavioral symptoms directed at others (threatening others, screaming at others, cursing at others). On 12/1/16, at 11:41 a.m. an interview was conducted with the licensed pharmacist who verified the last dose reduction for Seroquel had been on 8/20/15, reducing the Seroquel from 25 mg to 12.5 mg at bedtime.	F 329	F 329 Drug Regimen It is the facility□'s practice to monitor resident'□s medication regimen for efficacy and unnecessary medications following facility policy and regulatory requirements. Pharmacy recommendation for R47 was reviewed by the Nurse Practitioner and a gradual dose reduction attempt was initiated on 12/13/2016 with medication discontinued. Nurses were re-educated on the practice of timely follow up on pharmacy recommendations. Nurse Managers will follow up with providers regarding any items on the consultant pharmacist pending recommendations report. Random audits of pharmacy pending recommendations will be completed and data reviewed at QAPI meetings. QAPI team to determine duration and frequency of audits based on data obtained through audits. Responsible for compliance: Nurse Managers Responsible for overall compliance: Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 329	Continued From page 16 The facility's Psychotropic Drug Monitoring policy dated 11/12, directed staff to ensure "Dose reductions will be completed per regulatory guidelines or there will be documentation from the nurse practitioner (NP) or medical doctor (MD) indicating why a dose reduction is clinically contraindicated."	F 329		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 371	F 371	1/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 371	Continued From page 17 review, the facility failed to serve food in a sanitary manner on the 2 east and 3 east dining rooms. This had the potential to affect the 48 residents who were served meals in those dining rooms. Findings include: On 11/28/16, at 5:22 p.m. the 3 east dining area was observed. Dietary employee (DE)-B was preparing and serving French dip sandwiches. With bare hands, DE-B obtained a hot dog bun from the package, used a tongs to place the meat into the bun he was holding and then placed the sandwich on the plate. Nursing and other ancillary staff stood in front of the serving area as the food was dished. An ancillary staff (AS)-C went into the serving kitchen area to help with serving. AN-C also used bare hands to take a bun out of the package, open it and hand it to DE-B. On 11/29/2016, at 8:45:10 a.m. DE-C was observed wearing gloves while handling toast. DE-C touched the toaster handle and cupboard handle. DE-C did not change gloves after touching potentially unsanitary surface. At 8:59:12 a.m. DE-C stated she changed her gloves and washed hands between serving invididual resident food. At 5:54 p.m. AS-C was interviewed. AS-C stated she was new to helping with serving but had "never seen anyone using gloves." AS-C explained she was instructed to just serve the plates and remove dishes as needed. She was told to wash her hands prior to serving and whenever entering the serving kitchen area. When asked about touching food, she again reported she had not seen any staff wearing	F 371	FOOD Procedure It is the practice of the facility to provide food service in a manner that is esthetically pleasing and nutritional, utilizing proper sanitation and food handling methods. The Nutrition Services Director has re-educated staff on the practices for safe food handling. The Nutrition Services Director or designee will conduct regular and random audits to ensure proper food handling is occurring. Audits will be reviewed at the monthly QAPI Committee meetings and continue until the Committee considers the issue resolved. Responsible for compliance: Dietary Manager Responsible for overall compliance: Administrator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 371	Continued From page 18	F 371		

gloves. At 5:57 p.m. DE-B was interviewed. DE-B understood not to touch ready to eat food, but was confused because he had been instructed not to wear gloves.

At 6:22 p.m. registered nurse (RN)-B was interviewed. RN-B stated, "I'm not sure what the dietary rules are for touching food...have to wash your hands before touching anything. Not sure about dietary rules about touching ready to eat food." RN-B had also been helping to serve in the dining room.

On 12/01/16 8:26 a.m. registered dietitian (RD)-A was interviewed. RD-A explained they had recognized a problem with dietary staff not changing gloves appropriately when serving food. Staff would touch unsanitary items in the kitchen and continue working without changing gloves. She stated they had provided training for staff in past 4 to 6 weeks on when and how to properly wear gloves and encouraged the use tongs.

On 12/1/16, at 9:15 a.m. the director of nursing (DON) was interviewed. She explained that ancillary staff were scheduled to help in the dining rooms, and had been provided sanitation instructions for meal service. The instructions included not touching the inside of cups or food. "They are just to serve plates." The DON said instruction had been provided during customer service meetings and was not a formal training. The DON believed the nursing assistants (NAs) received safe food handling training from NA training courses and as a part of on the job training but did not have a specific check off for the training.

On 12/1/16, at 9:30 a.m. the dietary manager

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 371	Continued From page 19 (DM) was interviewed. She verified it was the policy of the facility to not touch ready to eat food with bare hands. The DM stated dietary staff had been trained on the proper use of gloving and to limit unnecessary use of gloves. She had identified a problem with staff not changing gloves and washing hands properly during food service. The DM explained the staff would touch unsanitary things in the kitchen with gloved hands and return to serving food and touching ready to eat food without changing gloves, and had received training to use tongs or other utensils for food handling. A Competency for Dietary Employees--Dietary Aides indicated staff were to "Provide and environment conducive to protecting the health and wellness of the patients and employees through high levels of sanitation standards." A folder of completed competencies and handout given to employees regarding proper use of gloves was provided and reviewed. The handout directed staff to only use gloves when handling ready to eat foods and to utilize utensils for serving.	F 371		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 428		1/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 428	Continued From page 20 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 428	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to act upon the consulting pharmacists's recommendation for a dose reduction in antipsychotic medication for 1 of 5 residents (R47) reviewed for unnecessary drug use. Findings include: R47's Pharmacy Review notes dated 12/11/15, revealed the registered pharmacist suggested the physician trial discontinuation of the antipsychotic Seroquel, as no behavioral symptoms were documented that warranted the continued use of the medication since it had been reduced from 25 to 12.5 milligrams (mg) on 8/15/15. In addition, a pharmacy note dated 6/6/16, was sent to the certified nurse practitioner (CNP) to the same effect. R47's 11/1/16, Physician Order Report indicated orders for Seroquel, an antipsychotic, 12.5 milligrams (mg) once daily at bedtime with start date of 8/12/15. R47's physician orders did not show additional dose reduction attempts since 8/20/15. Additionally, there was no documentation from R47's primary care provider regarding why a dose reduction was contraindicated. R47's diagnoses included dementia, anxiety, major depressive disorder, psychotic disorder, history of right cardiovascular accident and obsessive compulsive disorder. R47's Psychotropic Drug Use Care Area (CAA) dated 4/20/16, indicated R47 was taking antidepressants and antipsychotic medications for depression, anxiety, obsessive compulsive	F 428	F 428 Drug regimen review It is the facility□'s practice to have the drug regimen reviewed by the Consultant Pharmacist at least once per month and for the facility to act upon the Consultant Pharmacist recommendations. Pharmacy recommendation for R47 was reviewed by the Nurse Practitioner and a gradual dose reduction attempt was initiated on 12/13/2016 with medication discontinued. Facility process was discussed with the Medical Director on 12/8/2016. Nurse Managers will follow up with providers regarding any items on the Consultant Pharmacist pending recommendations report. Nurses have been re-educated on the proper practice of drug regimen review. Random audits of pending pharmacy recommendations will be completed and data reviewed at QAPI meetings. QAPI team to determine duration and frequency of audits based on data obtained through audits. Responsible for compliance: Nurse Managers Responsible for overall compliance: Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 428	Continued From page 22	F 428		

disorder, psychosis and dementia. R47's quarterly Minimum Data Set (MDS) dated 10/19/16, indicated R47 had mild cognitive impairment, experienced delusions and exhibited verbal behavioral symptoms directed at others (threatening others, screaming at others, cursing at others).

On 12/1/16, at 11:41 a.m. an interview was conducted with the licensed pharmacist (LP)who verified the last dose reduction for Seroquel had been on 8/20/15, when it had been reduced from 25 to 12.5 mg at bedtime. The LP explained there had been no response from the recommendations from R47's primary physician or CNP in 3/16, 6/16, or 9/16, although the resident had been seen by the primary physician after the recommendations were made. The LP stated she gave providers three months to respond to recommendations.

On 12/01/16, 2:18 p.m. registered nurse (RN)-A were interviewed and explained that the process was to send the medical record with an email copy to RN-A and the DON. RN-A confirmed the records had been sent to R47's medical provider, and if the provider did not respond, they continued to try to obtain a response. RN-A also verified a resident's medications were reviewed with quarterly assessments, as well as observations of the resident and care plan updates were made as needed.

On 12/1/16, at 3:00 p.m. the director of nursing (DON) verified the facility's process for gradual dose reductions (GDRs) and pharmacy recommendations. The DON said an email was sent to the DON and for the medical record, and then was placed in the CNP's folder for review.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 428	Continued From page 23 The CNP then checked the folder at the time of each visit, at least weekly. The DON said she was aware there had been a delayed response to pharmacy recommendations, and she had contacted the CNP's supervisor with concerns. The problem had been brought to the the quality assurance process improvement (QAPI) team for review. The facility's Psychotropic Drug Monitoring policy dated 11/12, directed staff to ensure "Dose reductions will be completed per regulatory guidelines or there will be documentation from the nurse practitioner (NP) or medical doctor (MD) indicating why a dose reduction is clinically contraindicated."	F 428		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and	F 431		1/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 431	Continued From page 24 disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, medication was not dispensed and stored according to standards of practice for medication administration, affecting 13 of 13 residents (R80, R25, R36, R51, R55, R66, R75, R87, R95, R96, R106, R107, R143) whose medication was	F 431	F 431 Drug records/label/storage It is the practice of the facility to dispense and store medications per standards of practice and per facility policies. TMA noted in survey tag is no longer a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 431	Continued From page 25 prepared for administration but was not immediately given. Findings include: Observations of medication administration was conducted on 12/1/16, at 11:37 a.m. Thirteen medication cups had been set up with residents' medications. Souffle cups containing resident medications were stored inside larger plastic cups labeled with resident names. Trained medication aide (TMA)-A explained at the time of the observation she was "running late." Licensed practical nurse (LPN)-A then came to the medication cart. TMA-A said LPN-A had instructed her in the process and stated, "You know I do this. We all do this." LPN-A denied providing the instruction and informed TMA-A it was an unacceptable practice and "You need to do this in real time." Registered nurse (RN)-A and the director of nursing were then apprised of the situation and arrived at the medication cart at 11:52 a.m. at which time TMA-A left the floor. RN-A stated the manner in which TMA-A was passing medications was unacceptable and not the way medications were passed in the facility. The DON stated, "This goes completely against our policy." Although medications remained in the cups not administered, the electronic medical records (EMRs) of the residents indicated some of the medications had been signed off as given by TMA-A. Some of the medications that had been set up had not been administered to residents timely while others had been set up for administration later that day. In some cases cups contained pills that had been set up for the wrong	F 431	facility employee. Per Facility protocol as noted earlier, OHFC reports were filed immediately for each resident who had medications prepared in med cart and documented as given before administered. Resident□s involved in the concern are identified as R80, R25, R36, R51, R55, R66, R75, R87, R95, R96, R106, R107, and R143. Nurses and TMAs were re-educated on facility practice for medication storage and documentation. Random audits of medication storage and documentation will be completed and data reviewed at QAPI meetings. QAPI team to determine duration and frequency of audits based on data obtained through audits. Responsible for compliance: Nurse Managers and staff education. Responsible for overall compliance: Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 431	Continued From page 26	F 431		

times according to the residents' physician orders. On 12/1/16, at 11:37 a.m. further investigation into the contents and types of medications in the cups was identified by RN-A and LPN-A who also confirmed the medications had been signed off as administered by TMA-A. The medications cups revealed the following:

R80's six medications were identified as Abilify (antipsychotic medication due and charted as given at 10:00 a.m.), Allopurinol (for gout due and charted as given at 10:00 a.m.), Carbidopa (for Parkinson's disease due at 6:00 a.m. 12:00 noon, and 5:00 p.m. and charted as given at 12:00 noon), Tylenol Extra Strength (for pain due at 6:00 a.m. 12:00 noon, 9:00 p.m. and charted as given for 12:00 noon), clonazepam (anticonvulsant commonly used for anxiety charted as given at 10:00 a.m.).

R25 had four medications identified as aspirin, calcium 600 with vitamin D3, multivitamin, and Klonopin (anticonvulsant commonly used for anxiety) all due to be administered at 9:00 and signed as administered.

R36 had four medications identified as atorvastatin (high cholesterol), calcium carbonate-vitamin D3, Ditropan XL (bladder control), and Zoloft (antidepressant) all due at 9:00 a.m. and signed as administered.

R51 had two medications, senna (laxative) and Tylenol (pain), both due at 9:00 a.m. and 5:00 p.m. It was unclear which dose was in the cup, as the 9:00 dose was signed off as administered and the 5:00 dose was not yet due for several hours.

R55 had seven medications identified as calcium

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 431	Continued From page 27	F 431		

citrate, Cymbalta (antidepressant/pain), folic acid, Neurontin (anticonvulsant commonly used for neuropathic pain), potassium chloride, thera vitamin, zinc sulfate were due at 10:00 a.m. and signed off as administered.

R66 had two medications identified as senna and Tylenol scheduled at 12:00 noon and the Tylenol and had been signed off as administered.

R75 had six medications identified as calcium, vitamin D3, Claritin (allergies) Effexor (antidepressant), Singular (asthma), and Toprol XL (beta blocker for heart). All six medications were due at 11:00 a.m. and five of the six (excluding Toprol XL) were signed as administered.

R87 had two medications identified as Metoprolol tartrate (beta blocker for heart) and Tylenol due at 12:00 noon and signed off as given.

R95 had Clindamycin HCL (antibiotic) in a medication cup that was due at 12:00 noon and was signed off as given..

R96 had three medications including Depakote ER (anticonvulsant commonly used for behavioral control) that was scheduled for 5:00 p.m. that had not been signed off as administered, as well as Tylenol and olanzapine (antipsychotic) scheduled for 12:00 noon and signed off as administered.

R106 had Sinemet (Parkinson's symptom control) in a cup that was scheduled for 11:00 a.m. and was signed as administered.

R107 had five medications identified as buspirone (anxiety), calcium-carbonate-vitamin D3,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 431	Continued From page 28	F 431		

multivitamin, senna, and Toprol XL were all scheduled to be given at 11:00 a.m. and were signed as administered.

R143 had six medications in a cup. Calcium was due at 12:00 noon, an the rest of the medications were all due at 8:00 a.m. and had been signed off as given: Losartan (high blood pressure), Metformin (diabetes control), Norvasc (heart), omeprazole (gastroesophageal reflux) and senna.

During an interview with TMA-B on 12/1/16, at 12:20 p.m. he explained he used the EMR to set up a resident's medication, administered the medication to the resident, and then documented that the medication had been administered. He stated he followed this process for one resident at a time and medications could be given one hour prior or following the ordered time in order to be considered administered timely.

On 12/1/16, at 2:22 p.m. during an interview with the DON, she verified medications were not to be set up in advance. "This is not the standard of practice and this is not our process or the expectations. The process was not followed."

The facility's 1/27/15, Medication Administration: General Guidelines policy read, "Medications are prepared at the time they are administered...Medications are administered within one hour before or one hour after the scheduled time or time frame according to facility...Unless otherwise specified by the physician, routine medications are administered according to the established medication administration schedule for the facility...Charting is to be done at the time medication is administered. The individual assigned to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	**625 WEST 31ST STREET 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 431	Continued From page 29 administer meds on each medication pass documents with initials on the MAR/EMAR."	F 431		
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 514		1/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 514	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure accurate documentation of medication administration, affecting 13 of 13 residents (R80, R25, R36, R51, R55, R66, R75, R87, R95, R96, R106, R107, R143) whose medications had not been given but had been documented as administered. Findings include: Observations of medication administration was conducted on 12/1/16, at 11:37 a.m. Thirteen medication cups had been set up with residents' medications. Souffle cups containing resident medications were stored inside larger plastic cups labeled with resident names. Trained medication aide (TMA)-A explained at the time of the observation she was "running late." Licensed practical nurse (LPN)-A then came to the medication cart. TMA-A said LPN-A had instructed her in the process and stated, "You know I do this. We all do this." LPN-A denied providing the instruction and informed TMA-A it was an unacceptable practice and "You need to do this in real time." Registered nurse (RN)-A and the director of nursing were then apprised of the situation and arrived at the medication cart at 11:52 a.m. at which time TMA-A left the floor. Although medications remained in the cups not administered, the electronic medical records (EMRs) of the residents indicated some of the medications had been signed off as given by TMA-A. Some of the medications that had been set up had not been administered to residents timely while others had been set up for	F 514	F 514 Accurate documentation of medications It is the facilities practice to document administration of medications per standards of practice and per facility policies. TMA noted in survey tag is no longer a facility employee. It was determined that none of the resident□s involved received medications at unscheduled times. Per Facility protocol as noted earlier, OHFC reports were filed immediately for each resident who had medications prepared in med cart and documented as given before administered. Investigations were completed within the 5 day requirement and submitted to OHFC. Nurse manager and LPN on unit interviewed residents involved in this concern prior to any medications being administered to them. The primary providers for each resident were updated on the concern on 12/1/2016. Resident□s involved in the concern are identified as R80, R25, R36, R51, R55, R66, R75, R87, R95, R96, R106, R107, and R143. Nurses and TMAs were re-educated on proper procedure for documenting medication administration. Random audits of EMAR documentation will be completed to monitor for early documentation of administration of medications and data reviewed at QAPI meetings. QAPI team to determine duration and frequency of audits based on data obtained through audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET 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 514	Continued From page 31 administration later that day. In some cases cups contained pills that had been set up for the wrong times according to the residents' physician orders. On 12/1/16, at 11:37 a.m. further investigation into the contents and types of medications in the cups was iidentified by RN-A and LPN-A who also confirmed the medications had been signed off as administered by TMA-A. The medications cups revealed the following: R80's six medications were identified as Abilify (antipsychotic medication due and charted as given at 10:00 a.m.), Allopurinol (for gout due and charted as given at 10:00 a.m.), Carbidopa (for Parkinson's disease due at 6:00 a.m. 12:00 noon, and 5:00 p.m. and charted as given at 12:00 noon), Tylenol Extra Strength (for pain due at 6:00 a.m. 12:00 noon, 9:00 p.m. and charted as given for 12:00 noon), clonazepam (anticonvulsant commonly used for anxiety charted as given at 10:00 a.m.). R25 had four medications identified as aspirin, calcium 600 with vitamin D3, multivitamin, and Klonopin (anticonvulsant commonly used for anxiety) all due to be administered at 9:00 and signed as administered. R36 had four medications identified as atorvastatin (high cholesterol), calcium carbonate-vitamin D3, Ditropan XL (bladder control), and Zoloft (antidepressant) all due at 9:00 a.m. and signed as administered. R51 had two medications, senna (laxative) and Tylenol (pain), both due at 9:00 a.m. and 5:00 p.m. It was unclear which dose was in the cup, as the 9:00 dose was signed off as administered and the 5:00 dose was not yet due for several hours.	F 514	Responsible for compliance: RN Nurse Managers and staff education. Responsible for overall compliance: Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	**625 WEST 31ST STREET 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 514	Continued From page 32	F 514		

R55 had seven medications identified as calcium citrate, Cymbalta (antidepressant/pain), folic acid, Neurontin (anticonvulsant commonly used for neuropathic pain), potassium chloride, thera vitamin, zinc sulfate were due at 10:00 a.m. and signed off as administered.

R66 had two medications identified as senna and Tylenol scheduled at 12:00 noon and the Tylenol and had been signed off as administered.

R75 had six medications identified as calcium, vitamin D3, Claritin (allergies) Effexor (antidepressant), Singular (asthma), and Toprol XL (beta blocker for heart). All six medications were due at 11:00 a.m. and five of the six (excluding Toprol XL) were signed as administered.

R87 had two medications identified as Metoprolol tartrate (beta blocker for heart) and Tylenol due at 12:00 noon and signed off as given.

R95 had Clindamycin HCL (antibiotic) in a medication cup that was due at 12:00 noon and was signed off as given..

R96 had three medications including Depakote ER (anticonvulsant commonly used for behavioral control) that was scheduled for 5:00 p.m. that had not been signed off as administered, as well as Tylenol and olanzapine (antipsychotic) scheduled for 12:00 noon and signed off as administered.

R106 had Sinemet (Parkinson's symptom control) in a cup that was scheduled for 11:00 a.m. and was signed as administered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	**625 WEST 31ST STREET 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 514	Continued From page 33	F 514		

R107 had five medications identified as buspirone (anxiety), calcium-carbonate-vitamin D3, multivitamin, senna, and Toprol XL were all scheduled to be given at 11:00 a.m. and were signed as administered.

R143 had six medications in a cup. Calcium was due at 12:00 noon, an the rest of the medications were all due at 8:00 a.m. and had been signed off as given: Losartan (high blood pressure), Metformin (diabetes control), Norvasc (heart), omeprazole (gastroesophageal reflux) and senna.

On 12/1/16, at 2:22 p.m. during an interview with the DON, she verified the facility's process was not being followed by TMA-A.

The facility's 1/27/15, Medication Administration: General Guidelines policy read, "Medications are prepared at the time they are administered...Charting is to be done at the time medication is administered. The individual assigned to administer meds [medications] on each medication pass documents with initials on the MAR/EMAR."

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245520 Y1	A. Building B. Wing Y2	1/19/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET MINNEAPOLIS, MN 55408

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0156	Correction	ID Prefix	F0282	Correction	ID Prefix	F0314	Correction
Reg. #	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18)	Completed	Reg. #	483.21(b)(3)(ii)	Completed	Reg. #	483.25(b)(1)	Completed
LSC		01/10/2017	LSC		01/10/2017	LSC		01/10/2017
ID Prefix	F0329	Correction	ID Prefix	F0371	Correction	ID Prefix	F0428	Correction
Reg. #	483.45(d)(e)(1)-(2)	Completed	Reg. #	483.60(i)(1)-(3)	Completed	Reg. #	483.45(c)(1)(3)-(5)	Completed
LSC		01/10/2017	LSC		01/10/2017	LSC		01/10/2017
ID Prefix	F0431	Correction	ID Prefix	F0514	Correction	ID Prefix		Correction
Reg. #	483.45(b)(2)(3)(g)(h)	Completed	Reg. #	483.70(i)(1)(5)	Completed	Reg. #		Completed
LSC		01/10/2017	LSC		01/10/2017	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	KS/mm	04/11/2017	28230	01/19/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 12/1/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: A1VZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00160

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245520**

2.STATE VENDOR OR MEDICAID NO.
(L2) **599340700**

3. NAME AND ADDRESS OF FACILITY
(L3) **REDEEMER RESIDENCE INC**
(L4) **625 WEST 31ST STREET**
(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 **12/01/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (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)
12/31

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

12.Total Facility Beds **129** (L18)
13.Total Certified Beds **129** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	129			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Dawn Chiabotti, HFE NEII 01/06/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/18/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **02/01/1988** (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.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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

CCN: 24 5520

On December 1, 2016, a standard survey was completed at the facility by the Minnesota Departments of Health and Public Safety to determine if thefacility 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 the facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F),

In addition, at the time of the December 1, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5520059 that was found to be substantiated at F431.

Refer to the CMS 2567 for health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 19, 2016

Mr. Danny Colgan, Administrator
Redeemer Residence Inc
625 West 31st Street
Minneapolis, Minnesota 55408

RE: Project Number S5520027, H5520059

Dear Mr. Colgan:

On December 1, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the December 1, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5520059 that was found to be substantiated at F431.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 10, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 10, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the 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, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 1, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 1, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

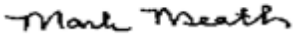
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING **01 - BUILDING 01** B. WING _____	**11/29/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	**625 WEST 31ST STREET** **MINNEAPOLIS, MN 55408**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on November 29, 2016. At the time of this survey, Redeemer Residence was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/29/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING **01 - BUILDING 01** B. WING _____	**11/29/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	**625 WEST 31ST STREET** **MINNEAPOLIS, MN 55408**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Redeemer Residence is a 3-story building with a full basement. The building was constructed at 3 different times. The original 3 story building was constructed in 1960 and was determined to be of Type II(222) construction. In 1975, a 3 story addition was constructed to the South that was determined to be of Type II(222) construction. In 1995, a 3 story addition was constructed to the East that was determined to be of Type II(222) construction. Because the original building and the 2 additions are of the same type of construction, the facility was surveyed as one building. This building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 129 beds and had a census of 104 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353	NFPA 101 Sprinkler System - Maintenance and	K 353		12/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING **01 - BUILDING 01** B. WING _____	**11/29/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	**625 WEST 31ST STREET 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 353 SS=C	Continued From page 2 Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and document review, the facility did not maintain and test their automatic fire sprinkler system in accordance with NFPA 25 and the 2012 LSC NFPA 101. 9.7.5, 9.7.7, 9.7.8. This deficient practice could effect all 104 residents. Findings include: On a facility tour between the hours of 1000 and 1500 on November 29, 2016, observation revealed that the facility did not have an adequate amount of spare automatic sprinkler heads. This deficient practice was verified by the director of maintenance at the time of inspection.	K 353	It is the practice of the Facility to comply with the Life Safety Codes related to sprinkler systems. The Facility has ordered, received and has on site the adequate number of spare sprinkler heads. To ensure compliance Maintenance Director will report to QAPI Committee on a regular basis the status of adequate sprinkler heads available on location at all times. Responsible Person: Maintenance Director	
K 541	NFPA 101 Rubbish Chutes, Incinerators, and	K 541		1/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING **01 - BUILDING 01** B. WING _____	**11/29/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	**625 WEST 31ST STREET** **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 541 SS=D	Continued From page 3 Laundry Chu Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not seal the vertical chute with the appropriate fire protective rating in accordance with the 2012 LSC NFPA 101. 9.5 Findings include: On a facility tour between the hours of 1000 and 1500 on November 29, 2016, Observation revealed that third floor laundry chute door was cracked and had holes through it.	K 541	The Facility has obtained a bid and has ordered replacement doors for the laundry chute. At the time of this writing the anticipated date for doors to arrive is undetermined by the supplier and installer due to the holidays. Responsible Person: Maintenance Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING **01 - BUILDING 01** B. WING _____	**11/29/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	**625 WEST 31ST STREET 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 541	Continued From page 4 This deficient practice was verified by the director of maintenance at the time of inspection.	K 541		
K 741 SS=D	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not provide a proper out door smoking area in accordance with the 2012 LSC NFPA 101. 19.7.4. This deficient practice could effect any residents or staff in the smoking area. Findings include:	K 741	The identified ash tray is located outside the building and has been corrected to be an approved receptacle. Other approved receptacles are in use. To ensure compliance Maintenance Director will conduct periodic audits of smoking areas and receptacles and report findings to the QAPI committee for review. Responsible	1/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING **01 - BUILDING 01** B. WING _____	**11/29/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	**625 WEST 31ST STREET 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 741	Continued From page 5 On a facility tour between the hours of 1000 and 1500 on November 29, 2016, observation revealed that the facility does not have approved, self-closing cigarette butt receptacles in the outdoor smoking area. This deficient practice was verified by the director of maintenance at the time of inspection.	K 741	Person: Maintenance Director	
K 918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable.	K 918		1/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING **01 - BUILDING 01** B. WING _____	**11/29/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	**625 WEST 31ST STREET** **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 918	Continued From page 6 Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on observation and document review, the facility did not maintain the emergency back-up generator in accordance with the 2012 NFPA 99. 6.4.4, 6.5.4, 6.6.4. These deficient practices could effect all 104 residents. Findings include: 1. On a facility tour between the hours of 1000 and 1500 on November 29, 2016, observation revealed that the facility could not provide documentation for a load percentage during the monthly generator run test. 2. On a facility tour between the hours of 1000 and 1500 on November 29, 2016, observation revealed that the facility could not provide documentation of conducting a cool-down period after the monthly generator run test. 3. On a facility tour between the hours of 1000 and 1500 on November 29, 2016, observation revealed that the facility could not provide documentation for conducting weekly visual generator inspections. These deficient practices were verified by the director of maintenance at the time of inspection.	K 918	It is the practice of the facility to maintain and test the generator according to the recommended guidelines. The deficiencies cited have been corrected. To ensure continued compliance audits of records for the required testing will be monitored on a regular basis and reported on at the QAPI meetings. Responsible Person: Maintenance Director	