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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: C4EJ

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 625**
(L4) **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 **1/3/2014** (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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A *** (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 :
Gayle Lantto, Unit Supervisor — 1/3/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 02/10/2014 (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
01/07/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

CCN=245520

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. In addition, at the time of the November 5, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5520052, H5520053, H5520054 that were found to be substantiated and subsequently corrected .Please refer to the CMS 2567B. Effective December 19, 2013, the facility is certified for 129 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245520

January 15, 2014

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 3, 2014, 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.

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Mr. Danny Colgan, Administrator
Redeemer Residence INC
625 West 31st Street
Minneapolis, MN 55408

RE: Project Number S5520024

Dear Mr. Colgan:

On November 27, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 31, 2013. 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 3, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 20, 2013 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 October 31, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 3, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 31, 2013, effective January 3, 2014 and therefore remedies outlined in our letter to you dated November 27, 2013, 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. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Gayle Lantto

Gayle Lantto, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 651-201-3794 Fax: 651-201-3790

Enclosure
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245520	A. Building B. Wing	1/3/2014

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 12/25/2013	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 12/25/2013	ID Prefix F0315 Reg. # 483.25(d) LSC	Correction Completed 12/25/2013
ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 12/25/2013	ID Prefix F0465 Reg. # 483.70(h) LSC	Correction Completed 12/31/2013	ID Prefix F0469 Reg. # 483.70(h)(4) LSC	Correction Completed 01/03/2014
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By 16022	Date: 1-3-14	Signature of Surveyor: 15507	Date: 1-3-14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?
10/31/2013	YES NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245520	01 - BUILDING 01	12/20/2013

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0038	11/06/2013	ID Prefix Reg. # NFPA 101 LSC K0062	11/08/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By 16022	Date: 1-3-14	Signature of Surveyor: 28120	Date: 12/20/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/5/2013

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: C4EJ

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 **10/31/2013** (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:

X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * 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 :
Lisa Hakanson, HPR, Dietary Specialist 12/16/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 12/24/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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

CCN=245520

At the time of the standard survey completed November 5, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. In addition, at the time of the November 5, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5520052, H5520053, H5520054 that were found to be substantiated.The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7630

November 27, 2013

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

RE: Project Number S5520024 and Complaint Numbers H5520052, H5520053, H5520054

Dear Mr. Colgan:

On November 5, 2013, 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. In addition, at the time of the November 5, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5520052, H5520053 (from 2013) and H5520054 (from 2014).

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 November 5, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5520052, H5520053, H5520054 that were found to be substantiated.

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

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

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

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

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

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

<u>Informal Dispute Resolution</u> - 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
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3794
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 10, 2013, 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 December 10, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the

Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 31, 2014 (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 May 1, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	10/31/2013

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 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A complaint investigation/s had been completed at the time of the standard recertification survey. Investigation/s of complaint H5520052 had been completed and had been substantiated. Deficiency/s had been issued as a result of the substantiated findings at F315 and F469. Investigation/s of complaint H5520053 had been completed and had been substantiated. Deficiency/s had been issued as a result of the substantiated findings at F465 and F469. Investigation/s of complaint H5520054 had been completed and had been substantiated. Deficiency/s had been issued as a result of the substantiated findings at F469.	F 000	POC accepted 12/16/13 Atlantic RECEIVED DEC 16 2013	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	F282 Continued on next page	12/25/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dan Colgan | TITLE: Administrator | (X6) DATE: 12/11/13

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

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	245520	A. BUILDING _____ B. WING _____	10/31/2013

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F 282	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the care plan for 1 of 1 resident (R113) reviewed for grooming needs. Findings include: On 10/28/13, at 12:58 p.m. R113 was observed sitting in his wheelchair in the dining room. The resident was unshaven. The resident was identified as requiring extensive assistance with personal hygiene. On 10/29/13, at 12:00 p.m. the resident was observed sitting in his wheelchair in the common area unshaven. At 5:00 p.m. the resident was in the dining room his hair appeared to be uncombed and he was unshaven. On 10/30/13, at 2:16 p.m. the resident was observed watching television in the common area, he was unshaven and his hair was uncombed. Document review of the care plan dated 8/8/12, for R113 addressed a problem with dressing, grooming, and bathing stating the resident was at risk of decline being independent with activities of daily living (ADLS) related to impaired cognition, cardiac disease, anemia, weakness and deconditioning. The goal was for the resident was to maintain ability to participate with parts of dressing and grooming. Staff was to approach R113 with limited to extensive assist of one staff with dressing and grooming. Staff was to set up supplies and encourage R113 to complete tasks	F 282	It is the policy of Redeemer Health and Rehab Center to assure that services needed by residents are provided by qualified persons in accordance with each resident's written plan of care. Resident 113 has been clean shaven. His care plan and resident care sheet have been reviewed and remain current. Staff has been re-educated regarding his plan of care for grooming. His on-going care is being monitored by the nurse manager. Nursing staff will be in-serviced by December 25, 2013 regarding policy on grooming. On-call staff and those staff on leave of absence will be educated through a read and sign packet which will include the grooming policy. Random audits of grooming will be done by nurse managers. Audit results will be reported to QA Committee for review and determination of need for ongoing audits or change in frequency. Nurse Managers are responsible for compliance. Director of Nursing is responsible for overall compliance.	

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F 282	Continued From page 2 after set up. The resident's quarterly Minimum Data Set (MDS) dated 2/13/13, stated the resident needs extensive assistance with dressing, personal hygiene and total dependent on bathing needs. Also the MDS denoted R113 had a diagnosis of dementia. On 10/29/13, at 10:34 a.m. during an interview, the resident's family member stated the resident does not always get shaved and she wished they would make sure the resident was shaven daily. On 10/30/13, at 2:30 p.m. the 3rd floor registered nurse (RN)-C verified the resident needed assistance with bathing and grooming and the plan of care was not followed. During document review the policy titled "Shaving the Resident " revised on June 2000 stated the purpose was to remove facial hair and improve the resident's appearance and improve morale.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents	F 312	F312 It is the policy of Redeemer Health and Rehab Center to assure that residents who are unable to carry out activities of daily living receive the necessary services to maintain good grooming per the resident's preferences. Continued on next page.	12/25/13

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F 312	Continued From page 3 received the services to maintain personal grooming for 1 of 1 resident (R113) reviewed for grooming needs. Findings include: On 10/28/13, at 12:58 p.m. R113 was observed sitting in his wheelchair in the dining room. The resident was unshaven. The resident was identified as requiring extensive assistance with personal hygiene. On 10/29/13, at 12:00 p.m. the resident was observed sitting in his wheelchair in the common area unshaven. At 5:00 p.m. the resident was in the dining room his hair appeared to be uncombed and he was unshaven. On 10/30/13, at 2:16 p.m. the resident was observed watching television in the common area, he was unshaven and his hair was uncombed. Document review of the care plan dated 8/8/12, for R113 addressed a problem with dressing, grooming, and bathing stating the resident was at risk of decline being independent with activities of daily living (ADLS) related to impaired cognition, cardiac disease, anemia, weakness and deconditioning. The goal was for the resident was to maintain ability to participate with parts of dressing and grooming. Staff was to approach R113 with limited to extensive assist of one staff with dressing and grooming. Staff was to set up supplies and encourage R113 to complete tasks after set up. The resident's quarterly Minimum Data Set (MDS) dated 2/13/13, stated the resident needs	F 312	Resident 113 has been clean shaven. His care plan and resident care sheet have been reviewed and remain current. Staff has been re-educated regarding his plan of care as it relates to grooming. His on-going care is being monitored by the nurse manager. Nursing staff will be in-serviced by December 25, 2013 regarding policy on grooming. On-call staff and those staff on leave of absence will be educated through a read and sign packet which will include the grooming policy. Random audits of grooming will be done by nurse managers. Audit results will be reported to QA Committee for review and determination of need for ongoing audits or change in frequency. Nurse Managers are responsible for compliance. Director of Nursing is responsible for overall compliance.	

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F 312	Continued From page 4 extensive assistance with dressing, personal hygiene and total dependent on bathing needs. Also the MDS denoted R113 had a diagnosis of dementia. On 10/29/13, at 10:34 a.m. during an interview, the resident's family member stated the resident does not always get shaved and she wished they would make sure the resident was shaven daily. On 10/30/13, at 2:30 p.m. the 3rd floor registered nurse (RN)-C verified the resident needs assistance with bathing and grooming. During document review the policy titled "Shaving the Resident " revised on June 2000 stated the purpose was to remove facial hair and improve the resident ' s appearance and improve morale.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively	F 315	F 315 It is the policy of Redeemer Health and Rehab Center to assess each resident and provide a plan of care to minimize the risk of decline and/or to restore as much normal bladder function as possible. All residents are assessed on admission, quarterly, annually and with significant change for bladder and/or bowel incontinence to prevent decline in bladder/bowel function. Continued on next page.	12/25/13

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F 315	Continued From page 5 reassess a change in urinary continence status for 1 of 3 (R106) residents reviewed who had a change in continence status. Findings include: R106 was interviewed on 10/31/13, at 10:09 a.m. and stated that he did have occasional urinary incontinence and that he would get sudden urges to go, and that staff might not respond quickly enough. He confirmed he was dry and did not have to go at the time of interview, but added, "I may have to in 5 minutes." R106's was observed on 10/31/13, at 10:09 a.m. which revealed R106 sitting in a wheelchair at a dining room table. There was no odor of urine or stool, the resident appeared well-groomed. The admission Care Area Assessments (CAA) dated 5/23/13, indicated, "Resident is at risk of incontinence with use of lasix, impaired mobility, CVA [stroke]. He is usually continent, with occasional incontinence. Staff toilet upon his request and monitor skin, and for any s.s. [sign or symptoms] of infection. Staff encourage adequate intake of fluids," and care plan (CP) considerations included "WILL CP to maintain highest level of continence." An Observation Report note dated 8/20/13, indicated R106 noted the following: - R106 was frequently incontinent of urine (R106 had a change from occasionally to frequently and was incontinent on the night shift as noted in the Point Click Care [electronic record] from the 5/23/13 MDS, forward), - R106 had no trial of a toileting program, nor was currently on one, - The section noted as Voiding Difficulties.	F 315	R106 has had his urinary continence reassessed and a trial bladder program has been initiated, the care plan and resident care sheet have been updated for incontinence interventions. His on-going care is being monitored by the nurse manager. Nurse Managers re-educated on bladder assessments and the need to identify contributing factors and implement a change in the care plan when a modifiable change in bladder status is identified. Random and periodic audits of bladder observations will be completed by Director of Nursing. Audit results will be reported to QA committee for review and determination of need for ongoing audits or change in frequency. Nurse Managers are responsible for compliance. Director of Nursing is responsible for overall compliance.	

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F 315	Continued From page 6 Voiding Difficulties determined R106's voiding was one of "Urgency," - The "Able to defer voiding?" question and the "Identify urological investigations done ..." boxes were left empty/unaddressed (R106 had previous urinary workup per RN-B which not identified on the assessment). - Onset of Bladder Incontinence category was answered as, "..noted on prior assessment." (The facility did not re-assess the change in bladder function for R106 from being occasionally incontinent to being frequently incontinent.) - Signs and Symptoms of Urinary Incontinence included "Urgency - Unable to suppress." - Medications were cited as a possible cause, - The type of incontinence was identified as "Functional," the "Urge" category was left unchecked (even though the facility had already identified R106's voiding as urgency in the Voiding Difficulties section), - and the "Physical examination performed and recorded" box was checked "No." R106's urinary status was not comprehensively assessed as the facility did not complete the visual inspection. Although R106 had a change from occasionally to frequently incontinent of urine the facility did not comprehensively reassess R106's incontinence to determine an appropriate toileting program. R106's quarterly Minimum Data Set (MDS) dated 8/21/13, indicated R106 was frequently incontinent of urine, was not on a toileting program and required extensive assistance to toilet. R106 was administered medications which included furosemide (a diuretic). The MDS assessment of 8/21/13, indicated that a toileting program was not being used to manage urinary incontinence. However, the previous admission MDS dated 5/23/13, included R106 was	F 315		

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F 315	Continued From page 7 occasionally incontinent of urine, but was not on a toileting program. The Nursing Notes were reviewed from 9/12/13, going forward and the following was noted. A Nursing Note dated 9/12/13, indicated at 10:15 a.m. R106 came to the nursing station and asked to be assisted to the bathroom. He was assisted but did not urinate nor have a bowel movement. The note went on to explain that R106 had been toileted before breakfast, at 9:00 a.m., 9:30 a.m., 9:45 a.m., and at 10:45 a.m. Another Nursing Note, dated 10/27/13, read, "Resident slept most part of the night and easily aroused...He was helped to move up in bed, his urinal were [sic] emptied several times during the night." The care plan problem for toileting dated 10/21/13, indicated that R106 was incontinent of bowel and bladder, and directed staff to check and change every two hours or assist to commode. The care plan goal was for R106 to be clean, dry and free of odor. Nursing assistant/registered (NAR) card instructions included the following information: - 5/31/13, "continent of B&B, staff assist with toileting;" - 8/23/13, "continent of B&B, staff assist with toileting;" - 10/29/13, "incontinent of B&B, check and change every two hours or assist to the commode." Point of Care NAR documentation of urinary incontinence between the dates of the admission MDS and the 90 day MDS indicated every incontinent episode charted was on the night shift. Registered nurse (RN)-B verified in an interview	F 315		

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F 315	Continued From page 8 on 10/31/13, at 8:32 a.m. R106 had a stroke, and used the call light to ask for bathroom assists, and sometimes he was found to have been continent. He stated further that R106 had a urinary workup in the past for the incontinence, but nothing had been pursued lately. On 10/31/13, at 9:04 a.m. license practical nurse (LPN)-H clarified R106 was rarely incontinent when in his room and awake, that he used the call light to get assistance to the toilet, and would make it in time. He further stated the times when R106 was incontinent had been when R106 was outside and could not make it back to unit in time. He added that the other situation in which R106 might be found incontinent was on the night shift, when he might be too sleepy to ring, and might be found on the two hour check to have been incontinent. On 10/31/13, at 11:32 a.m. RN-C, indicated that Point of Care charting triggered the incontinence MDS change. She explained that she would interview the nursing assistants staff, review nurse manager observation charting and progress notes, and that all these are taken into consideration in the final assessment score. On 10/31/13, at approximately 3:20 p.m. RN-E stated, "As far back as I can remember he's been incontinent." RN-E verified if a resident changed from continent to incontinent a change should be made in the care plan.	F 315		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441	F441 Continued on next page.	12/25/13

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F 441	Continued From page 9 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure that emesis	F 441	It is the policy of the facility to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment to prevent the development and transmission of disease and infection. This deficiency has been corrected. Basins were immediately removed and relocated after discovery and medication/treatment carts were cleaned. Nurses and TMAs were re-educated on infection control policy in regards to maintaining cleanliness of medication /treatment carts. Random and periodic audits will be completed by nurse manager/designee. Audit results will be reported to QA committee for review and determination of need for ongoing audits. Nurse Managers are responsible for compliance. Director of Nursing is responsible for overall compliance.	

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F 441	Continued From page 10 basins and wash basins were stored and cleaned in a sanitary manner. This had the potential to affect 4 of 24 residents (R25, R129, R34, R91) on the Lake Superior unit. In addition, the facility failed to ensure that medication and treatment carts were cleaned and maintained in a sanitary manner for 4 of 5 units (Lake Calhoun, Cedar Lake, Lake of the Isles and Lake Superior). This had the potential to affect 102 out of 123 residents who potentially received medication(s) from the carts. Findings include: Basins: On 10/29/13, the following observations were made: - At 8:26 a.m. an emesis and wash basin for R25 were stored on the floor under sink and were visibly soiled; - At 8:55 a.m. the shared bathroom for R129 had two soiled basins stored on floor in bathroom; - At 9:20 a.m. a wash basin for R34 was observed stored in the bathroom on the floor under the toilet tank. A wet wash cloth and a nightgown were in the basin; - At 10:11 a.m. two stacked wash basins for R91 were observed stored behind the toilet seat on the toilet itself. During an environment tour on 10/30/13, at 3:00 p.m. licensed practical nurse (LPN)-D stated that basins are to be washed, labeled and put at the bedside. She verified that storing basins in the bathroom on the floor or on the toilet was not the proper procedure. A facility policy and procedure titled Cleaning/Disinfection, updated august 2013,	F 441		

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F 441	Continued From page 11 read, "it is the policy of Elim Care, Inc. to keep the environment clean and microbiologically safe. To prevent infection in resident, staff and visitors. Reusable articles/equipment shall be cleaned on a regular schedule. Disinfect all equipment after use on patients in contact precautions. May be processed in an automatic washer." Medication carts: On 10/28/13, at 8:30 a.m. on Lake Calhoun, medication storage cart and the treatment cart was observed to have dried liquid spills down the sides of the cart and inside the drawers where medications were stored. The Cedar Lake medication storage cart had a black substance buildup, brown/red/pink liquid substance that was dried and had run marks down the sides of cart. On 10/31/13, at 8:20 a.m. the Lake of the Isles, the medication and treatment cart had a sticky brown substance inside the drawers and down the sides of the cart. That was confirmed by registered nurse (RN)-C. On Lake Superior, the medication and treatment carts had a dried liquid spills down the sides of the cart and inside the drawers. That was confirmed by licensed practical nurse (LPN)-C. Policy and procedure Infection Control 8/13, indicated medication carts will be thoroughly cleaned with appropriate disinfectant weekly and staff were to wipe cart(s) with disinfectant as needed.	F 441		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465	F465 Continued on next page	12/31/13

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F 465	Continued From page 12 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a clean, safe and sanitary environment related to the upkeep of shower rooms, dirty utility rooms, lighting, hand rails exhaust vents and garbage cans. This had the potential to affect all 123 residents in the facility. Findings include: An environmental tour was conducted on 10/30/13, at 2:00 p.m. with the administrator and the director of environmental services (DES). Multiple areas of the facility were found to be in an unclean condition. These findings were verified by the director of environmental services (DES). Shower stall drains had a thick buildup of hair and other debris in the 2nd floor east (2E) and 1st floor west (1W) bathing rooms. There was the potential for residents to contact the dirty drains with their feet. There was soap scum build up on the tiles in the shower staff on 2E. Floors of the soiled utility rooms on 3E, 2E, 2W, and 1W were dirty looking and had loose debris around the trash and soiled clothing bins. The DES stated, "we need to go through all of them" and added that the floors needed scrubbing. On 2E there were black spots on the floor. The 1W soiled utility room had brown drip stains on the	F 465	The practice and goal of the facility is to provide and maintain a clean and sanitary environment. This deficiency has been corrected and sited areas have been cleaned, lights have been replaced, ventilation remedied and handrails repaired. Bi-annual ventilation cleaning was in process as scheduled during the survey but had not yet been completed. To maintain compliance, procedures have been updated and staff have been re-educated on housekeeping procedures to maintain a clean and sanitary environment. Preventative Maintenance will include auditing handrails for proper condition and ventilation for proper functioning. Floor scrubbing of utility rooms will be scheduled to maintain proper cleanliness and to remove black marks. To ensure compliance, DES will conduct period and random 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 _____	10/31/2013

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 465	Continued From page 13 wall behind the hopper. Lights were burned out in the 2E, 3rd floor E (3E) and 1W bathing rooms which housed both a tub and a shower (two lights in both 2E and 3E and one light in 1W). The burned out light in the 1W room was the one over the shower stall. Therefore, staff and residents would not have adequate lighting while showering. Handrails on the 1st and 2nd floors were worn in areas to the base wood. The DES stated that there was no system for attending to them. They would be maintained on an as needed basis. Ventilation was not working in the 3E and 2E bathing rooms and the 2E soiled utility room. The 2E soiled utility room had a strong odor. The odor had also been noted during stage one of the survey. Garbage cans in the dining areas on 3W, 2W and 1W were heavily soiled on the outside of the cans. The can on 3W had areas of old soiled tape on the top. A facility policy for cleaning showers dated 6/22/2009, indicated that showers were to be cleaned weekly and as needed. A policy for cleaning dining rooms indicated that dining rooms were to be cleaned after each meal. The policy directed staff to disinfect all surfaces and equipment. The garbage cans were not specifically indicated. A policy for wall care directed staff to clean walls on a daily basis.	F 465		
F 469 SS=F	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM	F 469	F469 is continued on the next page	1/3/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 469	Continued From page 14 The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain an effective pest control program for 12 of 12 residents (R38, R125, R83, R115, R169, R34, R91, R129, R49, R104, R19, R25). This had the potential to affect all 123 residents in the facility. Findings include: Reports of mouse siting's in residents' rooms was wide spread throughout the facility. Twelve residents reported seeing mice in their rooms during stage one survey interviews (R38, R125, R83, R115, R169, R34, R91, R129, R49, R104, R19, and R25). A family member for R86 reported seeing mice in the dining room, and thought the facility was not clean. On 10/28/13, at 1:00 p.m. R169 reported seeing mice in her room. There was a hole in the floor around the heating pipes. A white powder was observed on the pipes and floor around the whole. R169 stated that she had put powder in the area to help cover up a "mouse smell. " R169's son also verified the existence of mice in the room. On 10/30/13, at 12:50 p.m. Housekeeper (Hskp)-C stated he believed the mouse problem was getting better and did not see as many mouse droppings. Hskp-C went on to explain that there were several residents who ate snacks in	F 469	It is the practice of the facility to provide and maintain a clean and sanitary environment free from insects and rodents. The facility has been contracted with a professional pest control company for many years and doubled the visits to alleviate the identified problem. The facility, in its attempts to improve the situation, has now procured a different pest control professional. The patio door situation has been corrected. The sighting reporting system has been changed to improve communication. Residents have been addressed as to abstaining from eating in their rooms, balanced with trying to maintain a home-like environment and respecting resident rights; policy is for resident storing food in rooms to be in appropriate containers to prevent attraction of undesirable pests. Residents with pet birds must be able to contain their food in an appropriate manner to prevent rodents. Periodic audits will be conducted to ensure compliance. Responsible person: Director of Environmental Services.	

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F 469	Continued From page 15 their rooms and food crumbs would spill onto the floor. He explained that a resident who enjoyed eating popcorn in the room complained about mice. At 1:10 p.m. Hskp-D said he did not think the mouse problem was getting better. He said that he sweeps up droppings from almost every room. He explained that he would move dressers and other large furniture every day to keep up with the mouse droppings. At the time of the interview, room 236 was observed with droppings along edge of floor and behind dresser on both sides of the room. Hskp-D also stated that some residents ate in their rooms and one resident would put bread and popcorn under the chair to actually feed the mice. Hskp-D stated that a resident had purchased a type of scented oil to use in her room as a mouse deterrent. On 10/30/13, at 4:00 p.m. the director of environmental services (DES) explained the facility system for reporting mice. A log was kept in the maintenance department. Staff were trained to report siting's by either calling directly to the DES or reporting to their supervisor who would call in the siting to the environmental services department. The exterminator would then review the log to investigate the area of concern. The siting log was reviewed and revealed only one siting from 9/17/13 until 10/21/13. The siting report for 9/17/13, indicated that a mouse had been seen sitting under a bird cage eating bird seed that had fallen to the floor. The administrator and DES explained that mesh had been placed around the building, radiators had been checked with mesh placed,and poison and traps were all being used. The DES stated	F 469		

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F 469	Continued From page 16 that he felt they had just moved the mice around with the interventions by cutting disrupting their runways. Pest control technician (PCT)-A was interviewed via telephone on 10/31/13, at 10:00 a.m. He stated that the entry points into the building had been eliminated and now the issue was getting rid of the remaining mice in the facility. He was concerned about first keeping mice out of residents' rooms. He did point out that there was one continuing entry point at the patio door on first floor. He explained that the door had been left propped open during warmer months, despite his recommendations to keep it closed. He stated that he had mouse bait stations near the door outside and reported heavy activity at those stations. PCT-A said that last spring he spoke with the administrator and department leaders from each floor and emphasized to report all sightings so the PCT's would know where to go. He explained that reporting had been good for four to five months but now just a sighting or two noted in the log book. He believed the reporting was not accurate. He explained that he would get more reports directly from staff when on the floor. PCT-A stated that bird and animal food could be a source of continued food for the mice. He emphasized that cutting off food sources was a very important to help rid the facility of mice. PCT-A stated, "it would help tremendously to plug all holes, to get them out of residents' rooms." He stated that bird seed on the floor was also an issue. He explained that he would not have a problem with going through each area of the facility systematically, but had not been able to do	F 469		

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F 469	Continued From page 17 so. The reason given to him was that the facility did not have the staffing to do the prep work of removing all the baseboard radiator covers for an entire unit. The administrator was interviewed on 10/31/13, at 8:00 a.m. He explained that staff had been provided education to report all sightings and to keep food contained. He said they conducted environmental rounds on a regular basis and did periodic room audits. Also, residents would report at council meetings and there were fewer reported siting's from the residents. He knew that there were residents who ate snacks in their rooms, but they had not been restricted from eating in their rooms as it was "their right. " He stated that he thought the pest control company had gone through the building systematically to plug runways.	F 469		

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	245520	A. BUILDING **01 - BUILDING 01** B. WING _____	**11/05/2013**

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

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. 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 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us	K 000	POC ok FS 12-16-13 RECEIVED DEC 16 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 12-10-13
EXIT: 10-31-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dan Colgan | TITLE: Administrator | (X6) DATE: 12/11/13

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

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K 000	Continued From page 1 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 127 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 038	NFPA 101 LIFE SAFETY CODE STANDARD	K 038	K038 is continued on next page.	11/8/13

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K 038 SS=F	Continued From page 2 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 7.2.1.5.4. The deficient practice could affect all residents. Findings include: On facility tour between 10:150 AM and 12:15 PM on 11/05/2013, observation revealed that: 1. The door combination for the third floor stair doors is not posted 2. There are latches on the corridor side of the doors at or near rooms 251 and R7 This deficient practice was verified by the administrator at the time of the inspection.	K 038	This deficiency has been corrected. Door codes have been reposted and latches on storage room doors for 251 and R7 have been removed. To ensure future compliance periodic audits will be conducted. Responsible person: Maintenance Supervisor. Date: Nov 6, 2012	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by:	K 062	K062 This deficiency has been corrected. The pressure gauge has been installed and the sprinkler head has been replaced. To ensure on-going compliance periodic audits will be conducted. Responsible person: Maintenance Supervisor. Date: Nov 6, 2013	11/8/13

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K 062	Continued From page 3 Based on observation and interview, the facility has failed to inspect and maintain the sprinkler system in accordance with NFPA 13 and NFPA 25. This deficient practice could affect some residents. Findings include: On facility tour between 10:150 AM and 12:15 PM on 11/05/2013, observation revealed that: 1. There is no pressure gauge at the top of the standpipe in Stair A 2. The fire sprinkler head in the 2W North Hall soffett is leaking and corroded This deficient practice was verified by the administrator at the time of the inspection.	K 062		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7630

November 27, 2013

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number F5520022 and Complaint Numbers H5520052, H5520053, H5520054

Dear Mr. Colgan:

The above facility was surveyed on October 28, 2013 through October 31, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint numbers H5520052, H5520053, H5520054 that were found to be substantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

When all orders are corrected, the order form should be signed and returned to:

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

Telephone: (651) 201-3794
Fax: (651) 201-3790

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gayle Lantto at (651) 201-3794.

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

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

Sincerely,

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File