*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
August 25, 2023

Administrator
Andrew Residence
1215 South 9th Street
Minneapolis, MN  55404

RE: CCN: 24E116
Cycle Start Date: August 3, 2023

Dear Administrator:

On August 3, 2023, a survey was completed at your facility by the Minnesota Department(s) 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition.  The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 9, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 9, 2023.  They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 9, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated.  Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans.  It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

## NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 9, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Andrew Residence will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 9, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

## ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

## DEPARTMENT CONTACT

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

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 3, 2024 if your facility does not

achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
August 25, 2023

Administrator
Andrew Residence
1215 South 9th Street
Minneapolis, MN  55404

Re: State Nursing Home Licensing Orders
Event ID: CJQ311

Dear Administrator:

The above facility was surveyed on July 31, 2023 through August 3, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>On 7/31/23 to 8/3/23, a survey for compliance with Appendix Z, the Emergency Preparedness Requirements for Long Term Care facilities, was conducted during a standard recertification survey. The facility was found not in compliance the the requirements.<br><br>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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained. | E 000 | | |
| E 041 SS=C | Hospital CAH and LTC Emergency Power<br>CFR(s): 483.73(e)<br><br>§482.15(e) Condition for Participation:<br>(e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.<br><br>§483.73(e), §485.625(e), §485.542(e)<br>(e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.<br><br>§482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1)<br>Emergency generator location. The generator | E 041 | | 8/29/23 |

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

Electronically Signed | 09/01/2023

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 |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 041 | Continued From page 1<br>must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.<br><br>482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2)<br>Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.<br><br>482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2)<br>Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.<br><br>*[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):]<br>The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource | E 041 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 041 | Continued From page 2<br>Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.<br>If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.<br>(1) National Fire Protection Association, 1 Batterymarch Park,<br>Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.<br>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.<br>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.<br>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.<br>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.<br>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.<br>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.<br>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.<br>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.<br>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.<br>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.<br>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.<br>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation | E 041 | The Facility timely submits this response | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 041 | Continued From page 3<br>and staff interview, the facility failed to test the Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.9, 8.4.9.1, and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 08/02/2023 between 09:00 a.m. and 12:00 p.m., it was revealed by a review of available documentation that the facility could not provide documentation showing that they have completed a four-hour test of the generator within the last 36 months.<br><br>An interview with the Executive Director, Director of Support Services, Maintenance Supervisor, and Maintenance Engineer verified this deficient finding at the time of discovery. | E 041 | and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency exists or that the statement of deficiency was correctly cited or factually based, and it is also not to be construed as an admission against interest of the facility, the administrator or any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same.<br>The facility maintenance staff has maintained ongoing completion and documentation of the required weekly and monthly testing of the Emergency Power Supply System (EPSS). The facility has also maintained an annual service agreement with an external power systems contractor to ensure that the EPSS is operating effectively and efficiently. Included in this annual service agreement has been a two-hour power systems load test ensuring the operational effectiveness of the equipment.<br>The facility contacted Zeigler Inc. (Power Systems Contractor) on August 23, 2023, and scheduled a four-hour power systems load test to meet the code requirements indicated above. This four-hour test was completed on August 29, 2023, and documentation verifying the test will be retained by the Environmental Services Director/Fire and Safety Director.<br>Continuing compliance will be maintained by the Environmental Services Director/Fire and Safety Director by scheduling another four-hour test on or | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 041 | Continued From page 4 | E 041 | before August 29, 2026.<br>The following steps have been taken to manage any future temperature issues:<br>1) No residents were identified as being affected.<br>2) The following measures have been implemented to prevent a recurrence of the issue:<br>• The annual service agreement with the Power systems contractor will include a four-hour power system load test to occur at least once every 36 months as per code requirements.<br>3) The following monitoring measures have been implemented:<br>• The maintenance department will add the four-hour power system load test to the preventive maintenance schedule.<br>4) The date the deficiency was corrected:<br>• August 29, 2023 | |
| F 000 | INITIAL COMMENTS<br><br>On 7/31/23 to 8/3/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>In addition to the recertification survey, the following complaints were reviewed<br><br>The following complaints were reviewed with no deficiency issued. HE1164044C (MN86038)<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the | F 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 | Continued From page 5<br>Departments 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.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. | F 000 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure hospital discharge records were reviewed to provide continuity of care and appropriate medication administration for 1 of 1 residents (R113) after they returned to the facility from the emergency department (ED). In addition, the facility failed to comprehensively assess and provide care in accordance with professional standards for 1 of 1 residents (R113) who had repeated episodes of hypoglycemia (low blood sugar).<br><br>Findings include: | F 684 | The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that:<br><br>Element 1 – Address how corrective | 9/9/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 684 | Continued From page 6<br>Continuity of care<br><br>R113's discharge Minimum Data Set (MDS) dated 7/7/23, indicated R113 did not have a Brief Interview for Mental Status (BIMS) completed and was independent with all activities of daily living (ADLs). R113's diagnoses included anxiety, depression, post traumatic stress disorder (PTSD), attention deficit disorder (ADD), alcohol abuse, diabetes, insomnia, transient ischemic attack (TIA) and cerebral infarction (causing temporary stroke symptoms and injury to the brain due to a lack of blood flow), high blood pressure, asthma, right knee replacement, polyneuropathy (decreased sensation to multiple extremities) and chronic pain.<br><br>R113's care plan dated 12/21/22, indicated R113 had pain related to a total right knee replacement, lower back disc degeneration, left shoulder pain and neuropathy. Interventions included administering medications as ordered. R113 also had high blood pressure. Interventions included receiving medications as ordered and promoting physical activity. R113 also had a history of drug (opioid) and alcohol abuse. The care plan also indicated R113 had neuropathy related to diabetes. Goals included managing R113's pain to maintain function of ADLs and participation in activities. Interventions included promoting diabetes management. R113 also had impaired memory related to a TIA and PTSD. Goals included maintaining her current level of functioning. No further interventions were indicated. The care plan lacked indication of, and interventions for, R113's use of antipsychotic medications, or R113's history of anxiety and depression. | F 684 | action will be accomplished for those residents found to have been affected by the deficient practice<br>Resident R113 will have discharge records reviewed upon return to the facility from ED/hospital discharge. Documents will be reviewed through information sent back with the resident's return, through the portal if accessible or through calling the ED/hospital, etc. to get the documents sent via fax/scan. R113 has been reassessed regarding her hypoglycemia. The physician was notified on 7/28/23 and reviewed and adjusted her scheduled insulin on 8/01/2023. An appointment has been scheduled with endocrinology per physician orders. R113 assessments are current including her BIMS. The indication of and interventions for use of antipsychotic medications as well as for anxiety and depression were available in the medical record in the physician orders and the resident's treatment plan for care and management of her diagnoses of F41.9 Anxiety disorder, unspecified F32.A Depression, unspecified, F43.10 Post-traumatic stress disorder, unspecified, F90.9 Attention-deficit hyperactivity disorder, unspecified type. The hypoglycemic policy will be reviewed/revised as needed including instructions if unable to wake a resident. R113 is independent with most of her daily tasks. Staff have reviewed diabetes management with R113, including meals and snack planning again with dietitian. Location of the Dexcom sensor on the body will continue to be on the MAR. R113 did have their A1c | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 684 | Continued From page 7<br>R113's Care Area Assessment (CAA) dated 12/30/22, indicated R113 triggered for cognitive loss/dementia, ADL function, psychosocial well-being, behavior symptoms, falls, activities, psychotropic drug use, and pain.<br><br>R113's orders dated 12/21/22, indicated R113 took the following afternoon and evening medications:<br><br>-Furosemide 40 milligrams (mg) at 9:00 p.m., a diuretic (to control fluid retention) for high blood pressure.<br>-Montelukast sodium 10 mg at 9:00 p.m., for asthma.<br>-Lyrica 150 mg at 4:00 p.m. and 9:00 p.m., for polyneuropathy.<br>-Propranolol 80 mg at 9:00 p.m., for high blood pressure.<br>-Rosuvastatin 20 mg at 9:00 p.m., for high cholesterol.<br>-Methocarbamol 500mg at 4:00 p.m. and 9:00 p.m., for muscle spasms.<br>-Tylenol 1000mg at 4:00 p.m. and 9:00 p.m., for chronic pain.<br>-Quetiapine fumarate 100 mg at 9:00 p.m., for anxiety.<br>-Amitriptyline 100 mg at 9:00 p.m. for depression.<br>-Trazadone 200 mg at 9:00 p.m., for depression.<br>-Buspirone 30 mg at 9:00 p.m., for anxiety.<br>-Clonazepam 1 mg at 9:00 a.m. and 4:00p.m., for anxiety.<br><br>During an observation on 8/1/23 at approximately 12:00 p.m., R113 was seen unconscious, lying face up on the floor outside the fifth-floor elevators. Staff assessing R113 reported her oxygen level to be 90% and all other vital signs within normal limits. No trauma was noted; 9-1-1 | F 684 | laboratory work completed 6/21/23 as scheduled and it was reviewed by the provider.<br><br>Element 2 – Address how the facility will identify other residents having the potential to be affected by the same deficient practice<br>Residents with diagnosis of diabetes and episodes of hypoglycemia will be re-evaluated including review/revise of care plan and interventions for diabetic management. Residents using sensors for glucose monitoring will have their care plans reviewed/revised as needed to ensure interventions for reading the sensor and identify what combination of sensor and finger stick checks will be used.<br>Residents with use of antipsychotic medications will continue to have their care plans reviewed at care conference to assure indication of and interventions are in place for use of antipsychotics.<br>Treatment plans, goals and interventions are reviewed in the quarterly treatment plan review/care conference as a part of their mental health and psychosocial needs, including medication review.<br>Records of residents who have returned from hospitalizations from 8/1/23 to current have been audited to ensure reconciliation of orders had been completed.<br><br>Element 3 – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 684 | Continued From page 8<br>was called and R113 was transported to the hospital.<br>R113's ED provider note dated 8/1/23, indicated R113 was discharged with no medication changes and received only 1000 milliliters of intravenous normal saline fluid while in the ED. No other medications were indicated as being administered.<br><br>R113's progress note dated 8/2/23 at 6:45 a.m., indicated R113 returned from the ED at approximately 11:00 p.m. without discharge paperwork. R113 requested, and was given, an as-needed (PRN) Percocet (an opioid) for pain. At 11:30 p.m., R113 requested propranolol and Clonazepam, stating she did not receive any medications while in the ER. The note indicated "Due to the lack of paperwork so staff could not determine what, if anything, she received at the hospital, as well as the late hour, it was determined to provide her with the propranolol, but not the Clonazepam."<br><br>During an interview on 8/2/23 at 7:59 a.m., R113 was in bed with a blanket covering her body and pulled over her head while a nurse was administering her insulin. R113 stated when she returned from the hospital the previous night, staff would not give her her afternoon or evening medications because "it was too late" and they could not call the hospital to verify what she received while she was there. R113 stated she was feeling anxious and "just bad all over" because she had missed her medications.<br><br>R113's progress note dated 8/2/23 at 3:30 p.m., indicated R113 did not see the exercise specialist that morning and declined her physical therapy appointment that day due to 7/10 pain. | F 684 | Licensed nursing staff will be re-educated to the following areas: discharge record review from ED/hospital, etc. for continuity of care, how to access discharge records, use of glucose monitoring sensors including documentation of sensor placement on the MAR, how to read and document readings as needed, following manufacturer guidelines, interventions, and notification of physician. Licensed staff will be re-educated to documentation of lab results and notification of physician/provider with a change of condition. All staff will receive re-educated on hypoglycemia and symptom identification. The Medical Director will be involved in the review of the revisions to the Hypoglycemia management policy and nursing protocol for residents returning from the hospital and the reconciliation of orders.<br><br>Element 4 – Indicate how the facility plans to monitor its performance to make sure that solutions are lasting<br>The Director of Nursing and/or designee will complete audits for five ED/hospital discharge records per week to assure staff reviewed documents upon return to facility and BIMS were completed and sent with resident, three care plans per week will be audited for diabetes management including hypoglycemia, indication and interventions for antipsychotic medications are included, three medical record audits per week for completed lab draws and documentation of results in the medical record, three medical record audits per week for | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 684 | Continued From page 9<br><br>During an interview on 8/2/23 at 9:45 a.m., registered nurse (RN)-C stated when R113 returned from the hospital on 8/1/23 at around 11:00 p.m., the phone line they usually call "would have been closed." Although, RN-C verified the staff could have called the ED to clarify what medications R113 was given while she was there. RN-C further stated staff had access to the hospital's computer system and could have looked up R113's hospital medical record and discharge summary to determine what had occurred during R113's hospital visit and what medications she had received, if any.<br><br>During an interview on 8/3/23 at 10:21 a.m., the assistant director of nursing (ADON) stated there was always a nurse at the facility who had access to the hospital medical record system. The ADON also stated staff should have looked at R113's hospital record to see what medications and treatments she received to ensure she did not overdose or miss doses of her medications, and to ensure continuity of care.<br><br>A facility policy regarding resident transfers from the hospital was requested but not received.<br><br>Hypoglycemia management.<br><br>The Centers for Disease Control and Prevention webpage titled, "Diabetes" dated 12/30/22, indicated standard blood sugar (BS) levels were:<br><br>-80-130 milligrams per deciliter (mg/dl) before a meal.<br>-Less than 180 mg/dl two hours after a meal.<br>BS levels below 54 mg/dl were classified as severe and may lead to altered mental status, | F 684 | change of condition and physician notification and three resident MAR's for documentation of glucose sensor placement on the body. The data collected will be presented to the QA committee by the Director of Nursing and/or designee. The data will be reviewed/discussed at the monthly Quality Committee. At this time, the committee will make the decision/recommendation regarding any necessary follow-up studies. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 684 | Continued From page 10<br>seizures, vision changes and weakness.<br><br>The CDC webpage also indicated uncontrolled BS levels can lead to serious health problems including heart disease, vision loss, kidney disease, coma, and death.<br><br>R113's care plan dated 12/21/22, indicated R113 had a chronic foot ulcer related to diabetes that resulted in the amputation of four toes and osteomyelitis and a history of hypoglycemia. Interventions included administering medications as ordered, promoting well-balanced meals to include protein and non-concentrated sweets, consulting medical professionals as needed, doing blood sugar (BS) checks as ordered, promoting daily physical activity. The care plan also indicated R113 had neuropathy related to diabetes. Goals included managing R113's pain to maintain function of ADLs and participation in activities. Interventions included promoting diabetes management. R113 also had impaired memory related to a TIA and PTSD. Goals included maintaining her current level of functioning. No further interventions were indicated.<br><br>R113's orders dated 12/21/22, indicated R113 had a Dexcom sensor device for glucose data management (a small device attached to the body with adhesive and a sensor wire just below the skin to monitor blood glucose levels. (The device alarms when BS levels are outside the resident's normal range and can be accessed through the resident's smart phone.) The orders also indicated to administer 1 milliliter (ml) of glucagon intramuscularly (IM) for signs of hypoglycemia and repeat after 15 minutes if signs persisted. The orders further indicated | F 684 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 684 | Continued From page 11<br>accuchecks (finger sticks) to be completed as needed for signs of hyper/hypoglycemia (high or low blood sugar). The orders indicated R113 was to have an A1c (blood test used to determine blood sugars over a period of time) drawn every three months to monitor her long-term blood sugar levelsand the next lab draw was ordered for 6/21/23.<br><br>R113's Lab Medication Administration Record (MAR) dated June 2023, lacked indication R113 had a blood draw completed for her ordered A1c on 6/21/23.<br><br>R113's diabetic progress note dated 6/8/23 at 3:45 a.m., indicated R113's Dexcom alarmed and indicated her BS was 41 mg/dl and a verifying fingerstick indicated it was 61 mg/dl. R113 ate a fig bar and drank apple juice and milk. The progress note lacked indication of R113's signs and symptoms. At 4:15 a.m., R113's Dexcom indicated a BS of 66 mg/dl. No further notes were documented to indicate further monitoring, treatment, or provider notification were done.<br><br>During an interview on 8/3/23 at 1:09 p.m., the assistant director of nursing (ADON) stated she was unable to find documentation that R113's provider was notified of her low BS on 6/8/23.<br><br>R113's diabetic progress note dated 6/24/23, indicated R113 missed her 7:00 a.m., BS check and insulin due to resident "sleeping" and not responding to three attempts to wake her. After R113 woke up at 9:00 a.m., R113's BS was checked, and she was administered insulin.<br><br>R113's diabetic progress note dated 7/26/23, indicated at 12:45 a.m., R113's BS was 41 mg/dl | F 684 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 684 | Continued From page 12<br>and she was displaying signs of hypoglycemia including altered mental status and lethargy. R113 was given a glucagon IM injection and at 12:50 a.m., R113's BS was 52 mg/dl. R113 was given Boost (a nutritional drink) and at 12:55 a.m., R113's BS was 76 mg/dl and no longer symptomatic. No further monitoring or treatment was documented, and no note was written to indicate R113's provider was notified.<br><br>R113's interdisciplinary (ID) progress note dated 7/26/23, indicated R113's roommate notified staff R113's Dexcom monitor was beeping, and showing R113 had a BS of 41 mg/dl. Upon entry to R113's room, staff found R113 difficult to awaken. Staff injected glucagon IM at 12:50 a.m., and at 12:55 a.m., R113 was more alert and able to chew a glucose tab and drink Boost. At 12:55 a.m., R113's BS was 76 mg/dl and her mental status was at baseline. R113 then went outside to smoke and was given more glucose tabs to chew in case her BS dropped again. At 1:45 a.m. R113's fingerstick was 174; however, at 3:30 a.m. her BS was down to 106. Staff indicated they would recheck R113's BS in two hours. The note lacked indication R113's provider was notified.<br><br>R113's ID progress note dated 7/26/23 at 7:03 a.m., indicated when staff attempted to recheck resident's BS at 5:30 a.m., they were unable to find where R113's the Dexcom monitor was located on her body and therefore did not recheck her BS; however, R113 appeared to be "sleeping with no issue." At 6:30 a.m., R113 was no longer on the unit.<br><br>R113's ID note dated 7/27/23 at 2:29 p.m., indicated R113 had been experiencing multiple episodes of hypoglycemia and had declined | F 684 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 684 | Continued From page 13<br>physical therapy that day due to being tired.<br><br>R113's IDT note dated 7/28/23 at 1:50 a.m., indicated at 11:32 a.m., R113 had a BS of 55 mg/dl and was dizzy, lethargic and confused. At 11:43 a.m., R113's BS was 115 and R113 was asymptomatic. Dexcom and fingerstick do not always match.<br><br>Review of a facsimile dated 7/28/23, indicated R113's provider was notified R113 had a recent increase in hypoglycemic episodes. R113's provider responded on 8/1/23, with an order to decrease R113's Novolog (insulin) from 50 units to 40 units at bedtime and to make an appointment with endocrinology (hormone/diabetic specialist).<br><br>During an interview on 8/2/23 at 9:45 a.m., registered nurse (RN)-C stated providers were "sometimes" notified of a resident's change in condition by a facsimile (fax) or a phone call. Staff were expected to write a progress note or on the back of the resident's paper, diabetic MAR to indicate if a provider was notified. When a resident's blood sugar (BS) level was between 55-70 milligrams/deciliter (ml/dl), and the resident was able to swallow, staff were to provide a snack with a mix of carbohydrates and protein, then recheck their BS after 15 minutes to ensure the resident maintained their BS above 70 mg/dl. If the resident's BS remained below 70 mg/dl, staff were to continue to provide snacks, notify the provider, and consider sending the resident to the emergency room. RN-C also stated giving only sugary snacks would be a concern because the resident's BS would increase initially but drop again after a short period of time. RN-C further stated staff were expected to attempt to wake a | F 684 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 684 | Continued From page 14<br>resident to check their BS, by knocking on the door and/or nudging them three times. No further instructions were provided if staff were unable to wake the resident.<br><br>During an interview on 8/3/23 at 10:21 a.m., the ADON stated if a resident's BS was 40 mg/dl they should be given food if they were able to eat or an intramuscular (IM) glucagon injection and their BS should be checked 15 minutes later, and the resident should continue to be monitored. The ADON stated she was unaware of a protocol for monitoring a resident who had low BS throughout the night but that it should be checked. The ADON further stated because the Dexcom monitor was not always accurate, any BS below 70 mg/dl should have been verified with a fingerstick.<br><br>During an interview on 8/3/23 at 2:00 p.m. R113 stated although she occasionally did not respond when staff attempted to wake her to check or recheck her BS, and if staff were unable to access her Dexcom, she wanted staff to do a fingerstick to ensure she was not hypoglycemic, causing her to be unconscious rather than sleeping.<br>R113's medical provider was not available for an interview.<br><br>During and interview on 8/3/23 at 1:35 p.m. the MD stated because the facility was designated a MHI, no care providers were able to go into the facility and therefore, all residents had their own psychiatrist who handled their mental health and a separate primary care provider (PCP) who handled the resident's medical conditions. The MD stated all PCPs had 24 on-call services the staff could contact in the event of a medical | F 684 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 684 | Continued From page 15<br>emergency; however, "many" psychiatrists do not have 24 hour availability; therefore the staff could call the MD 24 hours a day and she would help them "problem solve." The MD stated if she was unable to "problem solve" with the staff, the resident could wait until the following day, or the staff could send the resident to the emergency department. The MD stated in a "very rare case" she may refill a psychiatric medication over the weekend, but she only provided consultation to staff regarding resident psychiatric care. The MD stated she did not provide medical care for the residents and was not involved in the development of any medical policies or procedures such as diabetic or seizure care; and did not know who was.<br><br>The facility Management of Hypoglycemia Protocol indicated the following procedures:<br>-Level 1 = BS >/= 55 mg/dl but < 70mg/ml<br>-Level 2 = BS < 55 mg/dl<br>-Level 3 = A resident displaying altered mental status or a physical status requiring emergent intervention for the treatment of hypoglycemia.<br>Level 1 treatment included:<br>-Following interventions as noted by the resident's physician.<br>- Provide oral glucose (15-20 grams). The procedure lacked indication to withhold oral glucose if the resident had difficulty swallowing or had altered mental status.<br>-If BS remains below 70 mg/dl, repeat oral glucose and notify the physician. Also see Standing Orders.<br>Level 2 treatment included:<br>-Following intervention as noted by the resident's physician.<br>-Administer IM glucagon and repeat one time after 15 minutes if BS remains below 55 mg/dl or | F 684 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 684 | Continued From page 16<br>the resident remains symptomatic. See Standing Orders.<br>-Re-check BS within 15 minutes.<br>-If BS is within the established reference range, provide a meal or snack<br>-If BS remains below 70 mg/dl repeat oral glucose and notify the physician for further orders.<br>-Notify the provider.<br>Level 3 treatment included:<br>-Follow interventions as noted by the resident's physician.<br>-Call 911<br>-Administer IM glucagon and repeat one time after 15 minutes if BS remains below 55 mg/dl or the resident remains symptomatic. See Standing Orders.<br>-Notify the provider.<br><br>-Documentation should include the resident's BS before and after interventions, notification of the provider, any provider orders for treatment, plan of care for acute or chronic conditions, and a complete<br>assessment. The frequency and duration of continued monitoring will be determined by nursing clinical assessment and/or consultation with management and in conjunction with the resident's provider.<br><br>The facility Standing Orders dated 5/18/22, indicated to administer glucose 4 gram tabs (chew four tabs) for hypoglycemia and recheck BS after 15 minutes. Repeat if BS remains below 70 mg/dl. Administer 1 mg of IM glucagon for hypoglycemia: may repeat x 1 after 15 minutes if the resident remains symptomatic.<br>No further instructions were present regarding what hypoglycemia symptoms were or | F 684 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 684 | Continued From page 17<br>withholding oral treatment in the event the resident had altered mental status or difficulty swallowing. | F 684 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>During observation, interview and document review the facility failed to reassess a resident for safe smoking practices to prevent acute injury for 1 of 1 resident (R1) reviewed for smoking.<br><br>Findings include:<br><br>R1's annual Minimum Data Set dated, 6/21/23 indicated R1 was cognitively intact and was independent with activities of daily living (ADLs).<br><br>R1's Client Diagnosis Report dated 9/8/1993, indicated R1 was admitted to the facility with a diagnosis of schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly).<br><br>R1's most current smoking assessment dated 7/21/22, indicated R1 was assessed safe to smoke independently.<br><br>R1's progress notes dated 7/25/23, indicated a | F 689 | Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency exists or that the statement of deficiency was correctly cited or factually based, and it is also not to be construed as an admission against interest of the facility, the administrator or any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same.<br><br>Element 1 –<br>R1 was assessed for safe smoking practices using the Tobacco Use Screening UDA on 8/29/23. R1's care plan was reviewed with a care plan initiated.<br><br>Element 2 –<br>All residents who currently use tobacco, | 9/9/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 18<br>burn hole was noticed on R1's shirt by facility staff during a weekly meeting. R1 stated it was from "tobacco" and it was documented her speech became pressured and R1 further stated, "it happens too much. I'm klutzy with my smoking, it ruins my clothes and I hate it."<br><br>During an interview and observation on 7/31/23 at 12:59 p.m., R1 stated she often goes outside to smoke during the day independently. R1 had multiple holes in her shirt that were circular in nature approximately the size of a pencil eraser with charred, blackened edges.<br><br>During an interview on 8/1/23 at 1:08 p.m., social worker (SW)-B stated smoking assessments are done annually which would include a safe smoking assessment, observation of the resident smoking, and education on safe smoking practices. SW-B stated the expectation would be to reassess at any time if changes were noticed in a resident's condition or concerns were noticed such as burn holes in a resident's clothing. SW-B confirmed the most recent smoking assessment was 7/21/22.<br><br>During an interview on 8/3/23 at 8:48 a.m., program manager (PM) and social worker (SW)-C stated it was the PM who would conduct the safe smoking assessment to ensure the resident was not at risk for acute injuries from smoking materials.<br><br>SW-C stated he did not know the specific threshold for reassessment but stated if staff were seeing burn holes in a resident's clothing, it should be brought to the interdisciplinary team and the resident should be reassessed for safe smoking practices. | F 689 | who have evidence of burn holes in their clothing or other observations that may be evidence of unsafe smoking, will be reassessed for unsafe smoking by 9/9/23. Education will be provided to Program Managers on the Tobacco Use Screening Procedure and resident reassessment related to unsafe smoking practices to be reviewed by 9/9/23.<br><br>Element 3 –<br>The Tobacco Use Screening Procedure was revised to clarify the threshold for resident reassessment. Director of Clinical Services or designee, as part of a quarterly care plan review, will audit residents who smoke to ensure they have appropriate assessment and care plans in place.<br><br>Element 4 –<br>The results of these audits will be reviewed in Quality Assurance Performance Improvement meetings. The QAPI committee will review any trends or patterns and make recommendations to revise the plan of correction as indicated. At this time, the committee will make the decision/recommendation regarding any necessary follow-up studies. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 19<br><br>During an interview on 8/3/23 at 12:21 p.m., the assistant director of nursing (ADON) stated she was unaware of the smoking assessment policy and expectation as the "program managers managed that."<br><br>A policy titled Smoking and Vaping Policy and Procedure, dated 11/18/22, indicated residents were assessed for safe smoking upon admission to the facility and quarterly thereafter. | F 689 | | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning<br>CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure use of a continuous positive airway pressure (CPAP) machine was assessed or, if needed, managed to reduce the risk of complication (i.e., respiratory infection) for 1 of 2 residents (R163) observed to have such device present at their bedside.<br><br>Findings include:<br><br>R163's quarterly Minimum Data Set (MDS), dated 5/17/23, identified R163 had intact cognition and had several medical diagnoses including | F 695 | Andrew Residence timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency exists or that the statement of deficiency was correctly cited or factually based, and it is also not to be construed as an admission against interest of the facility, the administrator or any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified | 9/9/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 695 | Continued From page 20<br>non-traumatic brain dysfunction.<br><br>On 7/31/23 at 1:51 p.m., R163 was observed laying in bed while in their room. R163 had a dresser next to her bed which had a black-colored Luna II CPAP sitting on top. The device had visible, thick dust build up on the exterior and buttons, and the water chamber had visible water droplets on the walls (i.e., evaporation) inside of the chamber. A mask was attached to the machine and draped across the dresser. R163 stated she used the CPAP on a nightly basis and had used it for many years. R163 stated she cleaned, maintained and used the device on her own without staff involvement. When questioned on how she cleaned the machine (i.e., step by step process), R163 abruptly responded, "I know how to do it."<br><br>R163's care plan, dated 8/26/22, identified R163 had insomnia and sleep apnea (a sleep disorder in which breathing repeatedly stops and starts) and listed a goal which read, "Resident will achieve restful sleep, 7 of 7 nights," along with various interventions to help R163 meet this goal including, "Use and clean CPAP as directed." However, the care plan lacked any further information on the CPAP use, including if R163 managed/used the device on their own (i.e., set-up, cleaned, used).<br><br>R163's Physician Orders, dated 8/2023, identified R163 had insomnia and obstructive sleep apnea. The orders listed R163's medication regimen, however, lacked any directions or orders for CPAP use, including if R163 was able to manage the medical device on her own (i.e., self administration). In addition, R163's medical record was reviewed and lacked evidence R163's | F 695 | in the same.<br><br>Element 1 – Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice<br>Resident R163 will have completed an assessment of her knowledge and skills for use and care of the CPAP device, with the outcome of the assessment documented on the MAR and careplan in place for Insomnia and Sleep Apnea, including the resident's goals and preferences. Resident has been scheduled for an appointment 9/11/23 with her designated CPAP provider.<br><br>Element 2 – Address how the facility will identify other residents having the potential to be affected by the same deficient practice<br>Careplans, physician orders, and MARs for all residents currently using a medical respiratory device (CPAP or BiPAP) have been reviewed and audited to meet the protocols outlined in the revised policy "CPAP and BiPAP procedure".<br><br>Element 3 – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur<br>Facility policy and procedure "CPAP and BiPAP procedure" has been revised to include expanded protocols for teaching and assessment of the resident's knowledge and ability to use and care for the respiratory device. Protocols have also been expanded to provide guidance | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 695 | Continued From page 21<br>use of a CPAP had been comprehensively assessed for safety and ability; nor evidence the nursing staff were overseeing use of the device to ensure it was regularly cleaned and maintained to help prevent misuse or potential respiratory infection.<br><br>When interviewed on 8/2/23 at 10:18 a.m., licensed practical nurse (LPN)-A stated they had worked with R163 before and described them as "kind of isolative" in nature. LPN-A stated they were unsure if R163 used the CPAP present at their bedside adding it was a "good question." LPN-A explained the center' nursing team should be cleaning and maintaining the machine adding it should be listed on the MAR to ensure it was not missed. LPN-A reviewed R163's MAR and stated the CPAP use and cleaning was "not here [listed]," and reiterated they were not sure if the device was being used or not. LPN-A stated if the nursing staff weren't managing the cleaning of the device then nobody, including R163, was likely cleaning it regularly. LPN-A stated they would check into it and follow up.<br><br>During subsequent interview, on 8/2/23 at 12:28 p.m., LPN-A stated R163 used to be a nurse prior to admission, however, had cognitive diagnoses present which could impair her cognition and recall. LPN-A stated they visited with R163's program manager, and explained R163 admitted to the center with the CPAP adding they "don't know" why the device use and cleaning weren't listed on the MAR. LPN-A explained they followed up with R163 who reported using the device, so LPN-A showed R163 where to locate the distilled water and "going forward" will set-up nursing reminders for R163 to ensure the device is cleaned and maintained. LPN-A then pointed to | F 695 | on the monitoring and evaluation of use and effectiveness of the respiratory device. All nursing staff will receive education on the updates to the policy and procedure.<br><br>Element 4 – Indicate how the facility plans to monitor its performance to make sure that solutions are lasting<br>The Director of Nursing, or designee will complete weekly audits for a minimum period of 4 weeks to ensure 100% compliance and monthly thereafter. The data collected will be presented to the QAPI committee by the DON or designee. The data will be reviewed/discussed at the quarterly QAPI meeting. At this time, the committee will make the decision/recommendation regarding any necessary follow-up studies. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 695 | Continued From page 22<br>the mask, tubing, and water chamber which they had removed and placed in soapy water for cleaning at the nursing station. LPN-A stated they were "uncertain" if the center had a process or documented assessment to be completed if a resident was self-using devices like a CPAP; however, added such an evaluation would be good to complete as "competency needs to be known."<br><br>On 8/2/23 at 12:41 p.m., registered nurse (RN)-B was interviewed. RN-B explained CPAP use and cleaning was typically tracked on the MAR and R163's CPAP "must have just got missed." RN-B stated R163 likely needed some help or cues to safely use the device and ensure it was cleaned regularly. RN-B explained there was not a "formal assessment" to evaluate a resident' ability to manage a CPAP on their own as the discussion was "more informal" amongst the team. During subsequent interview, on 8/2/23 at 1:55 p.m., RN-B verified there was no formal assessment process to evaluate a resident' ability to self-manage a CPAP. RN-B stated there was no facility policy, to their immediate knowledge, regarding the self-use of the devices but there likely "will be going forward." Further, RN-B stated it was important to ensure CPAP devices were maintained and cleaned on a regular basis to reduce the risk of infection and ensure patient safety.<br><br>A Luna II CPAP / Luna II Auto CPAP User Manual, dated 7/2018, identified several cautions and warnings to be considered with use of the device to prevent malfunction or patient injury. A section labeled, "17. Cleaning," directed regular cleaning of the device and it's accessories was " ... very important for the prevention of respiratory | F 695 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 695 | Continued From page 23<br>infections." The manual directed to use mild soap to clean the device, and the water chamber was recommended to be cleaned on a daily basis.<br><br>A provided Use and Cleaning of Continuous Positive Airway Pressure (CPAP) Unit policy, dated 11/1999, identified the purpose of the document was to ensure residents using a CPAP was " ... properly instructed in the application and use of the unit, and that cleaning instructions [were] performed by staff as scheduled." The policy directed the nurse would instruct the resident on placing the device on a flat, sturdy surface, plugging in the unit, connect the tubing and headgear as instructed in the manual, and positioning the tubing to loop over the forehead and bed board without kinks. A section labeled, "Safety/Cleaning," directed each CPAP model varies but " ... every unit needs to be cleaned regularly." However, the policy lacked information on how resident self-use, including the steps listed in the policy, would be assessed or documented in the medical record to ensure competency and safety. | F 695 | | |
| F 697 SS=D | Pain Management<br>CFR(s): 483.25(k)<br><br>§483.25(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure reported complaints of neuropathic (i.e., nerve) and joint pain were | F 697 | The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted | 9/9/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 697 | Continued From page 24<br>comprehensively assessed and, if needed, interventions to promote comfort provided for 1 of 2 residents (R188) reviewed who reported severe pain during the survey.<br><br>Findings include:<br><br>R188's quarterly Minimum Data Set (MDS), dated 7/16/23, identified R188 had intact cognition, demonstrated no delusional behavior, and had several medical diagnoses including diabetes mellitus and schizophrenia. The MDS outlined R188 received both scheduled and as-needed (PRN) medication for pain during the review period, and he reported "severe" pain on a frequent basis which, at times, caused trouble sleeping at night.<br><br>On 7/31/23 at 2:22 p.m., R188 was interviewed, and explained he had pain in the left hip which stemmed from a childhood accident. R188 stated he felt the pain was not adequately controlled as the staff were only giving him Tylenol for it adding the medication was "not doing a thing." R188 explained he repeatedly had told staff the pain was bad and not controlled; however, their only response was telling him (R188) to "stay off my hip" and "lay down." R188 stated a physician appointment was scheduled offsite for his pain"sometime in August," however, there had been no discussion on what interventions, if any, were able to be done in the meantime to help provide comfort until the physician appointment could be completed. R188 stated the pain, at times, caused poor sleep and rated the pain "eight or nine [on 0/10 scale]" at it's worst over the past weeks.<br><br>R188's MDS Quarterly Assessments Review, | F 697 | as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that:<br><br>Element 1 – Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice<br>R188's care plan was updated on 8/2/23 to provide problem statement, goals and interventions for pain management related to chronic left hip pain. R188's comprehensive Pain Assessment was finalized on 8/6/23 and has been evaluated by his primary physician, podiatry, orthopedic provider and is scheduled for a physical therapy intake appointment.<br>Element 2 – Address how the facility will identify other residents having the potential to be affected by the same deficient practice<br>All resident records who were identified by MDS coding for a pain management program were audited to ensure that Comprehensive Pain assessments (UDA) have been completed, reviewed quarterly according to policy and careplans are in place for pain management.<br>Element 3 – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 697 | Continued From page 25<br>dated 7/14/23, identified a section labeled, "Pain Assessment," which outlined there had been a change since the previous annual assessment adding, "[R188] denied chronic pain concerns on admit although he has a diagnosis of [diabetes mellitus] w/ [with] diabetic neuropathy. Today he reports pain due to neuropathy ... a comprehensive pain assessment will be completed and the intervention for this added to this care plan." The evaluation provided spacing to answer if the care plan had been updated which was recorded with a, "X" marking next to, "Yes."<br><br>However, R188's corresponding Pain - Comprehensive Nursing Assessment, dated 7/14/23, was identified in the electronic medical record (EMR) and reviewed. The assessment provided spacing to record various aspects of R188's pain care needs and evaluation including the quality of the pain, location of pain, when it began, what improves or worsens the pain, and other various factors. However, the entire assessment was left blank and not completed.<br><br>R188's Physician Orders, dated 8/2023, identified R188's current medication regimen. This included Neurontin (an anti-convulsant used to treat nerve pain) 900 milligrams (mg) three times a day. There were no orders listed for Tylenol on the provided order set. R188's Medication Administration Record (MAR), dated July 2023, identified an order for acetaminophen 650 mg by mouth every four hours as needed (i.e., PRN) for pain or fever. A total of 14 administrations of the medication were recorded, with nine of them being given after the facility had identified potential pain concerns (MDS Quarterly Review, dated 7/14/23) which had not been | F 697 | The Director of Nursing will ask MDS Coordinator staff to report on status of pain assessments as a standing agenda item at regular MDS Coordinator meetings.<br>Element 4 – Indicate how the facility plans to monitor its performance to make sure that solutions are lasting<br>Director of Nursing or designee will conduct an audit of resident records weekly to ensure pain assessments and care plans including interventions are up to date for a minimum of 4 weeks to ensure 100% compliance and will continue auditing monthly or more as needed with data reports presented at quarterly QAPI Committee meetings.<br>Element 5 – Include dates when corrective action will be completed.<br>September 9, 2023 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 697 | Continued From page 26<br>comprehensively assessed. The associated "reason" for each administration was listed which included foot pain and hip pain, and the order had a written start date listed, "7-20-23."<br><br>R188's care plan, dated 5/29/23, identified R188 had diabetes, associated diabetic neuropathy, and severe psychiatric symptoms. However, the care plan lacked any recorded problem statements, goals, or interventions for R188's pain despite complaints of pain being identified several weeks prior, and the completed MDS review outlining the care plan had been updated to reflect these complaints. Further, R188's entire medical record lacked evidence R188's reported pain had been comprehensively assessed and, if needed, any interventions developed or implemented despite this pain being identified as a change (i.e., new pain) and R188 using multiple doses of PRN pain medication since it was identified on 7/14/23.<br><br>When interviewed on 8/1/23 at 12:21 p.m., registered nurse (RN)-A explained R188 was "very independent" with cares and had an active wound on their foot due to an excessive walking episode a few weeks prior. RN-A stated R188 did no complain of pain to their knowledge, however, if such complaints were received then the nurses would "do an assessment" if the complaints were "less routine [new]." RN-A explained the assessment would be nursing' responsibility to complete adding any complaints other staff are hearing should be reported as, "If somebody's not telling me, I can't do anything." RN-A reviewed R188's MAR and verified there was no formal pain monitoring in place, and explained care planning within the care center would likely be the MDS nurse' responsibility. | F 697 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 697 | Continued From page 27<br><br>On 8/1/23 at 12:34 p.m., RN-B was interviewed and reviewed R188's medical record. RN-B stated they were the person who loaded R188's Pain - Comprehensive Nursing Assessment (dated 7/14/23) and knew it still "had to be done," however, they got busy and "just ran out of time." RN-B stated they would complete the assessment soon and explained such assessments were typically done "immediately" when pain was identified, however, they had "dropped the ball." RN-B reviewed R188's care plan and verified it had not been updated with any interventions for pain adding it was likely due to the assessment not yet being completed. RN-B stated any formal pain monitoring would also be considered on a "case by case basis," which was usually done after the pain assessment was completed as staff then "have a much better idea" on pain control issues and subsequent needs. RN-B stated it was important to ensure complaints of pain were acted on immediately and assessed to help "provide the best possible care." RN-B added, "This just got away from me."<br><br>During and interview on 8/3/23 at 1:35 p.m. the MD stated because the facility was designated a MHI, no care providers were able to go into the facility and therefore, all residents had their own psychiatrist who handled their mental health and a separate primary care provider (PCP) who handled the resident's medical conditions. The MD stated all PCPs had 24 on-call services the staff could contact in the event of a medical emergency; however, "many" psychiatrists do not have 24 hour availability; therefore the staff could call the MD 24 hours a day and she would help them "problem solve." The MD stated if she was unable to "problem solve" with the staff, the | F 697 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 697 | Continued From page 28<br>resident could wait until the following day, or the staff could send the resident to the emergency department. The MD stated in a "very rare case" she may refill a psychiatric medication over the weekend, but she only provided consultation to staff regarding resident psychiatric care. The MD stated she did not provide medical care for the residents and was not involved in the development of any medical policies or procedures such as diabetic or seizure care; and did not know who was.<br><br>A provided Pain Management Program policy, dated 11/2022, identified psychiatric symptoms could likely not be adequately addressed until a resident was free of physical distress, including pain, and each resident had a right to pain management. The policy outlined, "Residents presenting with pain at other times [after admission] are assessed by the Floor Nurse and, if indicated, are referred to the Health Educator/MDS Coordinator for in-depth assessment, utilizing the Comprehensive Pain Assessment [underlined]." The information gathered would then be used to determine what, if any, interventions were needed for managing pain. | F 697 | | |
| F 699 SS=G | Trauma Informed Care<br>CFR(s): 483.25(m)<br><br>§483.25(m) Trauma-informed care<br>The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. | F 699 | | 9/9/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 699 | Continued From page 29<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to ensure specific triggers for post-traumatic stress disorder (PTSD) were comprehensively reassessed and care planned for, including medical and psychiatric interventions. This resulted in repeated seizures, numerous falls with head strikes and hospitalizations for 1 of 1 resident (R179) reviewed for trauma informed care.<br><br>Findings include:<br><br>R179's Record of Admission indicated R179 was admitted to the facility on 1/13/23 with several medical diagnoses to include bipolar disorder (A disorder associated with episodes of mood swings ranging from depressive lows to manic highs), major depressive disorder, PTSD (a condition of persistent mental and emotional stress occurring as a result of injury or severe psychological shock, typically involving a disturbance of sleep and constant vivid recall of the experience), and opioid use.<br><br>R179's Quarterly Minimum Data Set (MDS), dated 7/14/23, indicated R179 was cognitively intact and independent with all activities of daily living (ADLs).<br><br>R179's progress notes indicated R179 had 26 seizures, increasing in frequency, in the past 65 days requiring 11 hospitalizations and were documented as follows in the progress notes.<br><br>On 6/1/23, it was documented R179 was hospitalized on 5/31 for seizure activity in the community. | F 699 | Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions in the statement of deficiencies. The facility has appealed the alleged deficiencies and licensing violations. This plan of correction is prepared and executed as a means to continuously promote and improve quality of care and compliance with all applicable state and federal regulatory requirements and constitutes the facility's compliance.<br>In response to the above stated citation Andrew Residence has taken the following action:<br><br>Element 1 –<br>R179 was assessed for psychosocial behavior, treatments, orders, interventions, triggers, and care plan reviewed and updated for all with physician notified of any findings.<br>At the time of the survey, R179's, PTSD, was specifically focused on as part of her V16-Extreme Psychiatric Symptoms Vulnerability Care Plan with specific intervention related to potential triggers (i.e. avoiding transportation by males) as well as addressed in treatment plan Goal 1: Engage in activities that positively impact mental health. Triggers are assessed upon admission as part of the pre-admission intake process as well as in the Interpersonal Skills and Psychosocial Factors Assessment that is completed upon admission and annually thereafter. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 699 | Continued From page 30<br><br>On 6/3/23, in was documented R179 had seizure activity for 8 minutes.<br><br>On 6/12/23, it was documented R179 was hospitalized from 6/5 - 6/12 due to a concern for seizures and respiratory failure.<br><br>On 6/6/23, it was documented R179 had a seizure in the hospital requiring intubation (placement of an artificial airway).<br><br>On 6/10/23, it was documented R179 called the facility, stating she wanted to come home (to the facility) and not be in the hospital anymore.<br><br>On 6/18/23, it was documented R179 had intermittent seizures from 11:06 a.m. to 11:42 a.m. lasting 15 seconds to 6 minutes.<br><br>On 6/18/23, it was documented facility staff found R179 seizing in her bed and after 45 minutes was sent to the hospital.<br><br>On 6/19/23, it was documented R179 had seizure activity from 2:59 p.m. to 4:29 p.m. and from 7:39 p.m. to 7:59 p.m.<br><br>On 6/20/23, it was documented R179 had seizure activity from 7:27 a.m. to 8:03 a.m. and 2:00 p.m. to 2:40 p.m. and at 5 p.m. for approximately five minutes.<br><br>On 6/24/23, it was documented R179 had seizure activity from 8:16 p.m. to 8:27 p.m.<br><br>On 6/29/23, it was documented R179 had seizure activity at 1:32 p.m. for an hour. | F 699 | The 2567 indicates a PTSD assessment was not found; however, the Interpersonal Skills Assessment, the assessment in which we assess for trauma, was in the record dated 1/17/2023 and included information regarding her trauma history and triggers. When an Incident Report is completed, triggers to the incident are identified as part of the review process.<br><br>Element 2 –<br>All residents with PTSD will have care plans reviewed and revised by the Director of Clinical Services or designee. Care plan interventions will be created for identified triggers as appropriate.<br><br>Element 3 –<br>Policies revised to clarify process for monitoring triggers and updating care plans. Education will be provided to direct service staff on trigger monitoring and revising care plans to be completed 9/9/23. Direct service staff who have not worked a shift by 9/9/23 will complete the training at the time of their next scheduled shift. The Director of Clinical Services or designee, as part of a quarterly care plan review or as needed when trauma symptoms are identified, will audit residents with PTSD to determine appropriate/accurate care planning.<br><br>Element 4 –<br>The results of these audits will be reviewed in Quality Assurance Performance Improvement meetings. The QAPI committee will review any trends or patterns and make recommendations to | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 699 | Continued From page 31<br>On 7/1/23, it was documented R179 had seizure activity in the community and was sent to the hospital.<br><br>On 7/7/23, it was documented R179 was sent to the hospital for a 30-minute seizure.<br><br>On 7/9/23, it was documented R179 had a seizure in community and was sent to hospital.<br><br>On 7/10/23, it was documented R179 reported having a good weekend other than having to go to the hospital this weekend after having a seizure in the community.<br><br>On 7/11/23, it was documented R179 had seizure activity from 5:07 p.m. to 5:38 p.m. and from 7:20 p.m. to 7:42 p.m.<br><br>On 7/14/23, it was documented R179 was found on floor seizing at 6:57pm and seizure activity stopped at 7:03. R179 was sent to hospital for severe neck pain/headache and confusion post seizure/fall.<br><br>On 7/16/23, it was documented R179 had seizure activity lasting approximately five minutes after being found on the floor after a loud audible fall and was sent to the hospital.<br><br>On 7/20/23,it was documented R179 had two seizures, each lasting approximately seven minutes.<br><br>On 7/21/23, it was documented R179 met with the primary care provider who had concerns for a possible traumatic brain injury due to numerous falls with head strike. | F 699 | revise the plan of correction as indicated. At this time, the committee will make the decision/recommendation regarding any necessary follow-up studies. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 699 | Continued From page 32<br>On 7/31/2,3 it was documented R179 had seizure activity with "flashbacks".<br><br>On 8/1/23, it was documented R179 came out of her room at 9:15 p.m. and collapsed with a head strike, was nonresponsive for 10 minutes which was followed by two seizures. R179 was sent to the hospital.<br><br>On 8/2/23, it was documented R179 was sent to hospital twice for seizure activity.<br><br>R179's care plan lacked a specific focus area for PTSD. It did indicate R179 was at risk for injury related to seizures but lacked resident specific medical or psychiatric interventions to prevent seizures including specific triggers to avoid.<br><br>R179's electronic medical record (EMR) lacked comprehensive reassessments of R179 to include patterns of events leading up to R179's seizures, interventions to prevent PTSD episodes and seizures including what interventions have worked or not worked in the past. The EMR overall lacked proactive steps to take to prevent seizures which were believed to be caused by stress and anxiety according to R179's 2nd quarter treatment plan, dated 2/2/23.<br><br>During an interview on 8/2/23 at 8:24 a.m., R179 stated staff talk with her a lot but have not asked about what specifically triggers her PTSD and seizures, although she was unsure what they may be.<br><br>During an interview on 8/2/23 at 1:52 p.m., program director (PD)-A stated residents with a diagnosis of PTSD should be assessed using a user defined assessment (UDA) for PTSD which | F 699 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 699 | Continued From page 33<br>would be used to create a PTSD care plan with specific triggers. PD-A was unable to find a UDA for R179 related to her PTSD. PD-A stated R179 had an appointment set up with neurology and is working with her psychiatrist but no other changes have been made to R179's plan of care after repeated seizures and subsequent hospitalizations. PD-A stated R179's primary provider is updated via fax after each episode of seizure activity. The PD-A further stated specific triggers would be discussed as a staff meeting but these meetings were not documented.<br><br>During an interview on 8/3/23 at 8:19 a.m., registered nurse (RN)-D stated the seizure protocol was to wait five minutes and if the seizure continued then to call emergency medical services (EMS). RN-D stated during an active seizure the nurses "monitored vital signs." RN-D confirmed they did not have a specific seizure protocol for R179.<br><br>During an interview on 8/3/23 at 9:55 a.m., RN-D stated when a resident had a seizure, the staff took notes of what occurred, which would be recorded as a progress note, but there was not specific flow sheets or a protocol to use during or post seizure.<br><br>During an interview on 8/3/23 at 10:21 a.m., the assistant director of nursing (ADON) stated the facility's medical director was a psychiatrist who deferred medical concerns to the patient's primary care provider, and when they could not be reached to the emergency department at the hospital. The ADON stated the expectation for staff during a seizure was to monitor vital signs and call 911 after a resident was actively seizing for 5 minutes. The ADON stated staff are | F 699 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 699 | Continued From page 34<br>expected to keep the resident "safe" during a seizure and use oxygen if needed. The ADON acknowledged that R179's seizures were increasing in frequency stating that R179 was seeing a psychiatrist and neurology soon.<br><br>During an interview on 8/3/23 at 10:40 a.m., R179's primary care provider and medical doctor (MD)-A stated R179 had a very complex case and her seizure disorder was consistent with pseudoseizures (psychogenic nonepileptic seizures, previously known as pseudoseizures, usually have a psychological cause, such as severe mental stress. They are different from epilepsy and do not involve changes to electrical impulses in the brain) but that neurology would need to clear her of any true epileptic seizure disorder. MD-A stated pseudoseizures are typically managed with medical and psychiatric care and while R179 was seeing her in clinic she struggled with how to manage her care. MD-A stated R179 needed a complex protocol with medical and psychiatric interventions in place, stating she would love to collaborate with the facility and R179's psychiatrist but that had not been arranged. MD-A further stated the facility was good at updating her about seizure activity via fax, but stated it would be nice if she could touch base with facility staff in person or via phone for collaboration. MD-A stated R179 ultimately "needs more help and is unstable" stating she would benefit from an inpatient psychiatric unit or extensive psychiatric outpatient program.<br><br>During an interview on 8/3/23 at 11:15 a.m., MD-A stated she spoke with R179's psychiatrist who is going to reach out to her (psychiatrist's) supervising doctor to see, "what more we can be | F 699 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 699 | Continued From page 35<br>doing to prevent R179's seizures and hospitalizations" acknowledging that repeated hospitalizations was not beneficial to R179.<br><br>During an interview on 8/3/23 at 12:21 p.m., the ADON stated she had not contacted R179's primary care provider or psychiatrist via phone and did not believe the floor staff had either, stating they tried to call but often had to fax due to not being able to get ahold of the doctor. The ADON further stated waiting for the doctors to call back is challenging and frustrating.<br><br>During an interview on 8/3/23 at 1:06 p.m., the administrator stated facility staff are expected to use the resident's physician or on call physician for medical needs and to utilize the emergency department when they cannot be reached timely. The administrator confirmed the facility did not have a physician rounding group because they are a facility for mental health services and the facility "does not have enough money" for a rounding physician group. The administrator acknowledged that many residents admitted to the facility also had complex medical conditions.<br><br>During and interview on 8/3/23 at 1:35 p.m. the MD stated because the facility was designated a MHI, no care providers were able to go into the facility and therefore, all residents had their own psychiatrist who handled their mental health and a separate primary care provider (PCP) who handled the resident's medical conditions. The MD stated all PCPs had 24 on-call services the staff could contact in the event of a medical emergency; however, "many" psychiatrists do not have 24 hour availability; therefore the staff could call the MD 24 hours a day and she would help them "problem solve." The MD stated if she was | F 699 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 699 | Continued From page 36<br>unable to "problem solve" with the staff, the resident could wait until the following day, or the staff could send the resident to the emergency department. The MD stated in a "very rare case" she may refill a psychiatric medication over the weekend, but she only provided consultation to staff regarding resident psychiatric care. The MD stated she did not provide medical care for the residents and was not involved in the development of any medical policies or procedures such as diabetic or seizure care; and did not know who was.<br><br>A facility policy titled Seizure Procedure, dated 2/11/2002, indicated the nurse would initiate a Seizure Log and Neurological Assessment and Vital Sign Flow Record Form during a resident seizure, indicating the safety of the resident experiencing a seizure would be the priority of staff witnessing the seizure.<br><br>A policy on trauma informed care was requested but not provided. A course description of Trauma Informed Care training was provided, indicating the course examined "best practices as well as how to avoid actions that may be unknowingly harmful to clients." | F 699 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State | F 812 | | 8/3/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 812 | Continued From page 37<br>and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review the facility failed to ensure dishware and cooking utensils were properly sanitized (i.e., high temperature) in 1 of 1 commercial dishwashers observed in the main production kitchen. This had potential to affect all 206 residents, visitors, and staff who consumed food from the kitchen.<br><br>Findings include:<br><br>On 7/31/23 at 11:31 a.m., an initial kitchen tour was completed. A single ProPower commercial dishwasher machine was present in the kitchen and dishwasher (DW)-A was removing various items, including various dishware and cooking utensils, which had just been put through the machine for cleaning and sanitization. A series of three white-colored gauges were present on the machine which displayed wash temperature(s) and one labeled, "Final Rinse." On the soiled side of the machine (i.e., dirty), DW-B loaded another hard plastic rack with various kitchen items and loaded them into the machine for cleaning and sanitization; however, when the final rinse of the soiled cookware had completed the white-colored gauge displayed the final rinse temperature was | F 812 | The Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency exists or that the statement of deficiency was correctly cited or factually based, and it is also not to be construed as an admission against interest of the facility, the administrator or any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same.<br>1) In response to the low temperatures observed by the survey team, the maintenance staff adjusted the heating equipment that provides hot water to the dish machine on 8/2/23. The facility Environmental Services Director (ESD) did an additional assessment of the temp issue on August 3, 2023. The ESD assessment of the cause was that there may have been a call for 180 F water by both the dish machine and laundry equipment at the same time. On 8/3/23 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 812 | Continued From page 38<br>only 178 F (Fahrenheit). DW-B then loaded another rack with various dishware and loaded it into the machine; however, the final rinse temperature gauge displayed the final rinse temperature as only 176 F. DW-B was interviewed and expressed they were "not sure" if the machine was a high-temperature or chemical sanitization method adding nobody had ever directed or instructed them to check the gauges on the machine during the wash and rinse cycles. DW-B added they knew "nothing about the gauges." DW-A continued to remove the cleaned items and place them back in shelving and cupboards for future use.<br><br>On 8/2/23 at 8:38 a.m., a subsequent kitchen tour was completed. The same commercial dishwasher was in use with food service worker (FSW)-A loading various dishware and cooking utensils into the machine for cleaning. The machine completed the wash cycle and then activated the final rinse, however, the final rinse temperature displayed on the analog gauge was only 175 F. FSW-A loaded another rack with other, soiled kitchenware and dishware items and placed it into the machine. However, again, the final rinse temperature displayed on the gauge was 175 F. FSW-A was interviewed and expressed they were unsure if the machine was a high temperature or chemical sanitization method adding, "That's a good question." FSW-A then left the dishwasher area and returned with the food service manager (FSM) who reviewed the machine. FSM verified the dishwasher was a high-temperature sanitization method and the white-colored gauges were the ones used to monitor and check the machine' function. FSM then loaded a rack with soiled silverware and an empty silverware basin and ran it through the | F 812 | the ESD adjusted both the 180 F hot water tank and the 180 F hot water reservoir by increasing the water temperature level on the water tank and increasing the thermostat temperature level on the holding reservoir. After making the adjustments on 8/3/23, dish machine temperatures reported at appropriate levels when tested by both food service and maintenance staff. The ESD initiated additional 180 F temperature testing on the morning of 8/4/23 while operating both the dish machine and the laundry equipment on sanitizing cycles. Temperatures were continuing to maintain at appropriate levels when both dish machine and laundry equipment were operating at the same time. No additional temperature tests were observed by the survey team beyond the 8/2/23 tests.<br>The following steps have been taken to manage any future temperature issues:<br>No residents were identified as being affected.<br>2) The following measures have been implemented to prevent a recurrence of the issue:<br>• The Food Service department will continue monitoring the dish machine temperatures at mealtimes and are logging both the wash and rinse temperatures. The FSM and FSD will do periodic testing and logging of the rinse temperatures on the dish machine between meals.<br>• Appropriate food service staff will be educated on 9/6/23 in dish machine operation, temperature monitoring and | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 812 | Continued From page 39<br>machine, however, the final rinse temperature only recorded 174 F which FSM verified. FSM stated the final rinse cycle should be reaching 180 F to ensure the dishware was properly cleaned adding the machine had not been serviced "in awhile" but was due. FSM explained the staff had been using "test strips" on various loads to ensure it was reaching proper temperature, and retrieved these strips from the dining room before handing them to the surveyor. FSM stated they tested the machine using these strips on a weekly basis.<br><br>A package of orange-colored Taylor test strips were provided with directions to attach a test strip to a utensil or rack and washing the items with the strip attached. It directed, "If the color bar has turned bright orange, the dishwasher is maintaining the proper temperature." These strips were removed and were orange-colored with large font present reading, "180 F," and, "Pass When Blue Bar Turns Orange."<br><br>At 8:58 a.m., the food service director (FSD) joined the interview and demonstration of the dishwasher. A test strip was attached to a metallic utensil and ran through the machine on a rack. The final rinse, again, did not hit 180 F and the attached strips remained with a blue-tint upon exiting the machine. FSD stated they believed the machine to be functioning correctly and hitting the correct temperature adding the issue was "more than likely the gauge" being incorrect. A three compartment sink was adjacent to the dishwasher machine which FSD stated used the same hot water lines which fed the dishwasher. A new test strip was placed under the running hot water of the three compartment sink, and the strip turned orange with no blue-tint present on the | F 812 | ongoing logging. They will also be educated to notify the FSD, FSM or the maintenance staff immediately if dish machine temperatures fall below required levels.<br>• A replacement rinse gauge was ordered and installed on 8/15/23 to ensure that correct temperature levels are being recorded.<br>• Maintenance staff were educated on 9/1/23 regarding food service requirements pertaining to sanitation, dish machine assessment, and any equipment adjustments necessary to ensure that corrective response is quick and effective.<br>3) The following monitoring measures have been implemented:<br>• The Food Service department will continue monitoring the dish machine temperatures at mealtimes and are logging both the wash and rinse temperatures. The FSM and FSD will do periodic testing and logging of the rinse temperatures on the dish machine between meals.<br>• On 9/1/23 the maintenance department implemented temperature logs monitoring the hot water equipment temps on the 180 F hot water heater and holding tank.<br><br>4) The date the deficiency was corrected:<br>• August 3, 2023 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 812 | Continued From page 40<br>strip as had been the result when ran through the dishwasher. FSD acknowledged the strip color difference between the two but expressed they felt it was only "faintly" different adding the test strips used for quality monitoring on the dishwasher were not saved and immediately discarded.<br><br>A clipboard with a Dish Machine Temperature Log, dated 8/2023, flow sheet attached was then provided. The flow sheet identified a series of rows and columns which provided space to recorded the wash temperature, rinse temperature, and initials of staff recording the data for three meals on each respective calendar day with the third meal labeled, "Dinner," including an additional column labeled, "Surface Temp Reading." The rinse column identified the temperature should be, "min[imum] of 180," and all the recorded temperatures ranged 180-181 F. The only recorded surface temperature was listed as, "160." An additional Dish Machine Temperature Log, dated 7/2023, flow sheet was included outlined the same series of rows and columns to record the data for the machine. The final rinse column recorded temperatures which ranged 180 F to 182 F, and the surface temperatures recorded ranged from 155 F to 181 F.<br><br>FSD stated they had not been told and were unaware of any concerns with the commercial dishwasher not getting to 180 F during the final rinse cycle, but expressed it was important the machine did to "kill the bacteria and germs" which could remain on the dishware and cooking items. FSD reiterated the 180 F temperature importance, and stated a company was scheduled to review the dishwasher the same day | F 812 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 812 | Continued From page 41<br>(8/2/23) as the machine had developed some "sheeting" and was not removing rinse aide correctly which resulted in spotting on some pans and dishware. FSD stated the machine was supposed to be serviced every four months, however, had not been serviced in "seven [or] eight months" now due to the outside company having various issues.<br><br>When interviewed on 8/2/23 at 9:43 a.m., the registered dietician (RD) explained the facility' dishwasher was a high-temperature sanitization machine, and it had "been on our radar off and on" for several months due to the gauges potentially not reading correctly. RD stated the water entering the machine was kept at 180 F so they were not sure how the temperature could be falling out of range. RD explained they were onsite at the center the previous week and, at the time, the machine had been hitting the temperatures required (i.e., 180 F). RD stated they would recommend the machine, including the gauges, be inspected to ensure proper function adding they didn't realize the machine had been "temping out that low" as the surveyor observation. RD verified the test strips being used (i.e., Taylor) should turn bright orange if the temperature was obtained and FSD had also been testing the surface temperature of various dishware to ensure the rack level minimum temperature (i.e., 160 F) was obtained on the final rinse cycle. RD verified the final rinse cycle should be hitting 180 F (via gauge) or 160 F (via rack level) as "that's when the sanitization happens" to reduce the risk of foodborne illness adding, "It's clearly an important step."<br><br>On 8/2/23 at 1:29 p.m., a return visit to the kitchen was completed with FSD and FSM | F 812 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 812 | Continued From page 42<br>present. FSD verified they had been testing the surface temperature (i.e., rack level) of the machine and retrieved a handheld yellow-colored, infrared-style thermometer from the dining room area. A metallic pan was then loaded into a rack and ran through the dishwasher with the gauge labeled, "Final Rinse," again only hitting 175 F. Immediately as the metallic pan emerged from the dishwasher, FSD then used the thermometer to check the surface temperature of the dishware which resulted, "156 [F]," at the highest point. FSD verified the surface temperature did not hit, at minimum, the 160 F to demonstrate proper rack level rinse temperature.<br><br>A provided Cleaning and Sanitizing Food Contact Surfaces policy, undated, identified a purpose of preventing foodborne illness by ensuring all food contact surfaces were properly cleaned and sanitized. A section labeled, "6. If a dishmachine is used," directed to check with the manufacturer to ensure the data plate (i.e., gauges) was correct and to use the data plate to determine wash and final rinse temperatures, if applicable. Further, the policy outlined, "Ensure that food contact surfaces reach a surface temperature of 160 F or above if using hot water to sanitize." | F 812 | | |
| F 841 SS=F | Responsibilities of Medical Director<br>CFR(s): 483.70(h)(1)(2)<br><br>§483.70(h) Medical director.<br>§483.70(h)(1) The facility must designate a physician to serve as medical director.<br><br>§483.70(h)(2) The medical director is responsible for-<br>(i) Implementation of resident care policies; and<br>(ii) The coordination of medical care in the facility. | F 841 | | 10/15/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 841 | Continued From page 43<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review the facility failed to ensure the medical director (MD), who was a psychiatrist, actively participated in the development, implementation, and review of policies and procedures related to resident medical care. This had the potential to affect all 206 residents residing in the facility.<br><br>Findings include:<br><br>During an interview on 8/3/23 at 10:21 a.m., the assistant director of nursing (ADON) stated each resident had their own psychiatrist for mental health treatment and their own primary provider for medical care. ADON further stated, due to the facility being classified as a Mental Health Institute (MHI), although they were licensed as a nursing facility, the facility did not allow any providers to come into the facility to provide care and/or assessments to residents because the expense would not be covered by Medicaid. The ADON stated the facility tried to make appointments for the residents to see their personal psychiatrist every 60 days for their mental health and attempted to get into contact with their primary provider for their medical conditions; however, they did not always get a response from the primary providers.<br><br>During an interview on 8/3/23 at 1:45 p.m., the director of clinical services (DCS) stated the facility medical policies were created many years ago when the medical director of the facility was both an internist (medical physician) and a psychiatrist. The DCS stated the director of nursing (DON) and other non-physician staff reviewed the policies to ensure they were | F 841 | Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions in the statement of deficiencies. The facility has appealed the alleged deficiencies and licensing violations. This plan of correction is prepared and executed as a means to continuously promote and improve quality of care and compliance with all applicable state and federal regulatory requirements and constitutes the facility s compliance.<br>In response to the above stated citation Andrew Residence has taken the following action:<br><br>Element 1<br>The role and responsibilities of the Medical Director were reviewed with the Medical Director on 9/1/23. A Consulting Medical Services Advisor was contacted 8/29/23 and agreed to actively participate in the development, implementation and review of policies and procedures related to resident medical care specifically pharmacy recommendations, hypoglycemia management, comprehensive pain assessment and interventions, seizure procedures and trauma informed care by 9/4/23. The Medical Director and/or Consulting Medical Services Advisor will review/revise remaining resident medical care policies by 10/15/2023 and at least annually thereafter. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 841 | Continued From page 44<br>consistent with the "regulations." The DCS further stated if a policy or procedure that was out of their "scope" needed to be updated, the facility would "try to find someone" to review it, but the DCS was unsure who that would be. The DCS verified the facility medical director was not involved in the review of policies and procedures related to the medical care of the residents.<br><br>During an interview on 8/2/23 at 2:28 p.m., the consulting pharmacist (CP) stated because the resident's all had their own primary care provider (PCP), she often did not get a response to her recommendations and therefore, only made medication recommendations once a year. If the CP made a recommendation, she would set a reminder for herself in six months to review the resident's chart to see if the recommendations were addressed. The CP further stated some physicians were "completely unresponsive," and the facility had never found a "good way to follow up."<br><br>During an interview on 8/3/23 at 1:06 p.m., the administrator stated because the facility was an MHI, providers could not go into the facility to see the residents. The administrator stated after hours, staff would attempt to call the resident's PCP, however, it was very difficult to get a call back "timely." The administrator stated staff could also call the MD who would attempt to get ahold of the resident's PCP also. The administrator further stated if staff were unable to contact the PCP or their on-call provider, the resident would be sent to the emergency department.<br><br>During and interview on 8/3/23 at 1:35 p.m. the MD stated because the facility was designated a MHI, no care providers were able to go into the | F 841 | Element 2<br>Facility will work with the Medical Director and possibly other physicians (Consulting Medical Services Advisor) to fulfill the role and responsibilities.<br><br>Element 3<br>Director of Nursing and/or Director of Clinical Services will audit for completion the MD actively participated in the development and implementation of hypoglycemia management, comprehensive pain assessment and interventions, seizure procedures and trauma informed care.<br>The Policy and Procedure Tracking form was revised to ensure the Medical Director and/or Consulting Medical Services Advisor reviews facility policies and procedures regarding resident medical care to ensure residents receive appropriate medical care according to professional standards of practice.<br>Director of Nursing will review protocols for routing of Consultant Pharmacy medication regimen reviews with Medical Director including participation with provider response to pharmacist requests and recommendations. The consultant pharmacist has added notation to all reviews to request response within 30 days to the Director of Nursing.<br><br>Element 4<br>The Director of Clinical Services will present the data collected to the QAPI committee. The data will be reviewed/discussed at the quarterly QAPI Committee. At this time, the committee | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 841 | Continued From page 45<br>facility and therefore, all residents had their own psychiatrist who handled their mental health and a separate primary care provider (PCP) who handled the resident's medical conditions. The MD stated all PCPs had 24 on-call services the staff could contact in the event of a medical emergency; however, "many" psychiatrists do not have 24 hour availability; therefore the staff could call the MD 24 hours a day and she would help them "problem solve." The MD stated if she was unable to "problem solve" with the staff, the resident could wait until the following day, or the staff could send the resident to the emergency department. The MD stated in a "very rare case" she may refill a psychiatric medication over the weekend, but she only provided consultation to staff regarding resident psychiatric care. The MD stated she did not provide medical care for the residents and was not involved in the development of any medical policies or procedures such as diabetic or seizure care; and did not know who was.<br><br>Review of the facility seizure procedure dated 2/11/02, indicated any resident who had a seizure would be monitored for 24 hours. Residents requiring more acute medical attention would be sent to the emergency department for evaluation. The procedure also indicated residents with a seizure disorder were to use a shower rather than a tub for hygiene. If a tub was necessary, the resident would be monitored in the tub if bathing assistance was needed; otherwise, staff were to sit outside the tub room. No further interventions regarding the treatment of a resident having a seizure was documented, including maintaining a resident's airway, lowering them to the ground for safety, measures to ensure the resident did not aspirate during seizure activity, or the | F 841 | will make the decision/recommendation regarding any necessary follow-up studies.<br>The Director of Nursing Services will track and audit the dates of Consultant Pharmacist reviews and responses and report results to the QAPI Committee. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 841 | Continued From page 46<br>administration of oxygen.<br><br>Refer to:<br><br>F684<br>Based on observation, interview, and document review, the facility failed to ensure hospital discharge records were reviewed to provide continuity of care and appropriate medication administration for 1 of 1 residents (R113) after they returned to the facility from the emergency department (ED). In addition, the facility failed to comprehensively assess and provide care in accordance with professional standards for 1 of 1 residents (R113) who had repeated episodes of hypoglycemia (low blood sugar).<br><br>F697<br>Based on interview and document review, the facility failed to ensure reported complaints of neuropathic (i.e., nerve) and joint pain were comprehensively assessed and, if needed, interventions to promote comfort provided for 1 of 2 residents (R188) reviewed who reported severe pain during the survey.<br><br>F699<br>Based on observation, interview and document review the facility failed to ensure specific triggers for post-traumatic stress disorder (PTSD) were comprehensively reassessed and care planned for, including medical and psychiatric interventions. This resulted in repeated seizures, numerous falls with head strikes and hospitalizations for 1 of 1 resident (R179) reviewed for trauma informed care. | F 841 | | |
| F 880<br>SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f) | F 880 | | 9/9/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 880 | Continued From page 47<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to: | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 880 | Continued From page 48<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which 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; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review the facility failed to show proper infection control processes were in place when visibly soiled personal laundry was left unattended on top of a communal washing machine. This had the potential to affect all 206 residents residing in the facility with access to the washing machine.<br><br>Findings include:<br><br>During observation and interview on 8/2/23 at | F 880 | Andrew Residence timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency exists or that the statement of deficiency was correctly cited or factually based, and it is also not to be construed as an admission against interest of the facility, the administrator or any employees, agents or other individuals | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 880 | Continued From page 49<br>8:10 a.m., the 2nd floor locked laundry room contained two stackable washer and dryer units. Approximate dimensions of laundry room was five feet by five feet. On top of washing machine labeled, "#1" was a pile of visibly soiled personal laundry. On the very top of the pile of laundry was one blue undergarment with three visibly dried dark red stains that included the elastic of both leg openings into the crotch panel. To the right of this was a blue leopard print undergarment with dried dark amber colored stain of crotch panel. On the floor of the laundry room was another light dusty rose colored undergarment with dried dark yellow stained crotch panel. During interview with social services (SS)-A stated "dirty linen should not be here on the unit and left". SS-A stated the laundry room is shared by all the residents and soiled linen is "not sanitary".<br><br>During interview with facility infection control preventionist (IP) on 8/2/23 at 10:47 a.m., IP stated laundry procedures with residents are reviewed upon admission to the facility. IP stated visibly dirty laundry "should never be left unattended" in the unit laundry rooms due to infection control risk. IP stated soiled or dirty laundry can cause outbreaks in this facility". IP stated new admissions are instructed on facility laundry procedures and expectations.<br><br>R143's quarterly Minimum Data Set (MDS) dated, 5/10/23, indicated intact cognition.<br><br>During interview with R143 on 8/2/23 at 12:26 p.m., R143 stated she was informed on admission to facility on expectations of residents to perform their own laundry. R143 stated, "I cannot leave my dirty laundry unattended. You can't put it up there (pointing to the washing | F 880 | who participated in the drafting or who may be discussed or otherwise identified in the same.<br><br>Element 1 –<br>No resident identified. Resident laundry procedure, checklist and schedule were reviewed and no revisions were required. All resident laundry facilities were inspected and found to not have any soiled items.<br><br>Element 2 –<br>Residents who perform their own laundry tasks will be re-educated to the process and expectation of doing their laundry and maintaining infection control at their upcoming quarterly treatment plan review meeting.<br><br>Element 3 –<br>Program Managers will be re-educated to their role of observing and checking for individual resident adherence through observation. This will be completed by 9/9/23. On 8/31/23 the housekeeping team was notified of a revised cleaning schedule as well as re-education on notifying floor staff should they observed laundry left in the laundry facility.<br><br>Element 4 –<br>The Director of Clinical Services or designee will audit three resident's use of the laundry room for individual adherence to infection control process and completion of laundry weekly. The data collected will be presented to the QAPI committee by the Director of Clinical | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 880 | Continued From page 50<br>machine lid) and leave".<br><br>During interview with program director (PD) on 8/2/23 at 1:45 p.m., PD stated, "there should never be soiled personal laundry sitting on top of the washer machine because it is communally used and is a risk for infection". PD stated the facility uses a checklist for all new residents to explain to them the process and expectation of doing their personal laundry.<br><br>During interview with facility's maintenance director (MAD) on 8/3/23 at 8:46 a.m., MAD stated the expectation was soiled personal laundry should not be allowed to be left out. "It is not ok."<br><br>Form titled, Resident Orientation Checklist dated 3/20/23 stated day 5 is when Laundry Procedures: 1. Linen Day, 2. Use of floor washing machines, 3. Use of Andrew laundry services is reviewed with all new admissions. Form titled Resident Use of Floor Laundry Facilities dated 6/22/09 stated, "7. Each resident is expected to leave the Laundry Room and the laundry facilities clean and in order..." | F 880 | Services and/or designee. The data will be reviewed/discussed at the quarterly QAPI meeting. At this time, the committee will make the decision/recommendation regarding any necessary follow-up studies. | |
| F 925 SS=F | Maintains Effective Pest Control Program CFR(s): 483.90(i)(4)<br><br>§483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure structural repair recommendations from an outside pest control contractor were acted upon and | F 925 | The Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not | 9/1/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 925 | Continued From page 51<br>completed timely to reduce the risk of rodent or pest entrance into the care center. This had potential to affect all 206 residents, visitors and staff at the facility.<br><br>Findings include:<br><br>A Centers for Disease Control (CDC) How to Control Wild Rodent Infestations article, dated 1/2023, identified rats and mice were known to carry various diseases which could be spread to a human population. These diseases included salmonellosis, monkeypox, and tularemia. Further, the article outlined it was important to seal gaps or holes in exterior walls adding, "mice can fit through a hole the width of a pencil (1/4 inch or 6 millimeters in diameter)."<br><br>R106's annual Minimum Data Set (MDS), dated 5/26/23, identified R106 had intact cognition. On 7/31/23 at 1:58 p.m., R106 was interviewed and expressed the care center had "a little bit of a mouse problem." R106 explained they had seen mice within the nursing home, off and on, for a "couple months" including within the dining room which was next to the kitchen. R106 stated they thought the home had brought in an outside company to help address the issue, and explained even the food service director (FSD) had reported they turn the lights on in the dining room and the mice "just scatter" in the early morning hours. R106 stated they felt the issue had resolved until just last week when another female in the home screamed aloud they had "saw a mouse" run into the kitchen from the dining room.<br><br>R165's quarterly MDS, dated 7/15/23, identified R165 had intact cognition. On 7/31/23 at 2:29 | F 925 | admissions or an agreement that a deficiency exists or that the statement of deficiency was correctly cited or factually based, and it is also not to be construed as an admission against interest of the facility, the administrator or any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same.<br>No specific residents were identified as being affected in this survey. We believe that we have complied in maintaining an effective pest control program. We have followed protocol in addressing pest control issues that have been impacted by external situations and mandated covid demands. Our pest control records indicate that pest activity was impacted by covid mandates which resulted in the facility and the contracted pest control service committing significant time, labor, and resources in working on the situation. The ongoing efforts to manage pest activity have resulted in consistent gradual improvement.<br>To continue to manage pest issues, the following steps will be implemented:<br>1. The following measures have been implemented to manage pest control within the facility:<br>• The pest control service did a regular monthly service visit on 8/28/23. The service was directed on 8/28/23 to schedule a current building-wide effort to seal pest access routes. The facility is awaiting a scheduled date.<br>• Housekeeping staff were educated on 8/31/23 on inspection, pest activity signs, | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 925 | Continued From page 52<br>p.m., R165 was interviewed. R165 stated the care center had mice and, as a result, they had several traps present within their room. R165 stated they had reported mice activity to the maintenance department who, in turn, then placed additional traps in their room but expressed nothing else about plans to correct the issue.<br><br>When interviewed on 8/3/23 at 8:19 a.m., living skills instructor (LSI)-A stated a male resident on the 2nd floor had reported a mouse in their room just a day or two prior, which had been reported to the maintenance department. LSI-A stated they had not noticed or heard of concerns with mice or rodents prior.<br><br>On 8/3/23 at 8:26 a.m., mental health worker (MHW)-A was interviewed, and expressed they had never personally observed mice or rodents at the center, however, residents had complained about them off and on adding they had last heard a complaint a few months prior. MHW-A stated the maintenance department would be notified of any such complaints and then it was "in their hands after that."<br><br>When interviewed on 8/3/23 at 8:30 a.m., FSD stated they had seen mice in the dining room area but felt it had "been awhile," adding the last time was "at least a month ago." FSD stated the maintenance department was aware of the issue and, as a result, had EcoLab (an outside company) coming in and addressing it to their knowledge.<br><br>On 8/3/23, the reports from the outside pest control agency were requested and a blue-colored binder was provided. Inside, a series | F 925 | and cleaning procedures to address pest activity.<br>• Maintenance staff were educated on 9/1/23 regarding the pest control service reports, facility follow-up assignments, timely work order completion, and consistent logging of pest sightings, reporting and corrective action. Education also included information on regular inspection of both interior and exterior areas of the building and timely corrective action.<br>• A procedure was implemented on 9/1/23 to inform and effectively correct issues by the maintenance staff in a timely manner.<br>2. The following monitoring measures have been implemented:<br>• Regular pest control services will continue to be scheduled at least monthly or more frequently based on observed pest activity.<br>• Environmental staff have been educated to be proactive in assessing facility and property areas for pest activity to address more effectively. Maintenance staff was educated on 9/1/23 regarding doing regular inspection of both interior and exterior areas of the building.<br>• A procedure was implemented on 9/1/23 to inform and effectively correct issues by the maintenance staff in a timely manner.<br>• Staff will be reminded of the procedure of notifying maintenance staff when a pest sighting occurs. This education reminder will occur through all-staff email and facility newsletter delivery. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 925 | Continued From page 53<br>of paperwork was identified for each month work and/or inspection had been completed. These included:<br><br>A printed Ecolab Customer Service Report, dated 4/25/23, identified the care center was serviced and listed a section, "Pest Activity Found," which outlined no rodent activity had been located adding, "Spoke with and showed [Jason] structural concerns and findings related to rodent activity ... informed me of rodent catches in patient rooms and sightings in kitchen/dining area." A section was labeled, "Structural Concerns," which outlined a hole/gap was located around the wires entering the building for ventilation and fans on the East side of the building adding, "Gaps are large enough for rodent entry. Please seal to prevent pest entry." A corresponding column labeled, "Action Taken/Needed," identified, "Seal to prevent pest entry ... will reduce the numbers of pests entering the area." The report was signed by both the EcoLab service technician and maintenance personnel (MP)-A.<br><br>An additional printed EcoLab Customer Service Report, dated 5/16/23, identified the care center was again serviced and listed a section, "Pest Activity Found," which identified rodent activity was found in the exterior of the building, inside a storage room, and in the ceilings. The section labeled, "Structural Concerns," identified a hole/gap on the East side of the building was identified surrounding the area where air conditioning (AC) hoses entered the building, and a gap under the double doors by the garbage area which lead into the building. The report directed both areas should be sealed to prevent rodent entry and harborage. The report was | F 925 | 3. The date the deficiency was corrected:<br>• September 1, 2023 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 925 | Continued From page 54<br>signed by both the EcoLab service technician and maintenance personnel (MP)-A.<br><br>Further, a subsequent Ecolab Customer Service Report, dated 7/13/23, identified the care center was serviced and listed a section, "Pest Activity Found," which outlined mice had been found in exterior stations (i.e., traps). These traps were inspected and serviced. The section labeled, "Structural Concerns," outlined a hole/gap was found near the wall/ground junction on the northeast side of building between the AC unit and side door into the center. The area was treated and "temporarily sealed" with added dictation, "Please seal hole with more permanent material." The corresponding area marked, "Action Needed/Taken," outlined, "Seal to prevent pest entry or harborage ... measures here will reduce the number of pests entering the area." The report continued and another concern was listed which outlined a hole/gap was located in the back of the building next to the garbage area at the right base of the double doors entering the care center due to worn away concrete. This area was also treated and "temporarily sealed" which dictation present, "Please seal permanently." The report was signed by both the EcoLab service technician and maintenance personnel (MP)-A.<br><br>On 8/3/23 at 10:55 a.m., the maintenance director (MAD) and director of operations (DOO) were interviewed. MAD stated they had just started working the center about two months prior, and MP-A would likely the best person to visit with about follow-up to the printed Ecolab reports as they had typically walked with the technician for each visit. DOO stated there had been a "more expansive" issue with mice and rodents during the pandemic as residents were | F 925 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 925 | Continued From page 55<br>eating more in their rooms. As a result, they had a building walk-through with an outside pest control agency who, at that time, helped seal up various openings and fix identified structural concerns. DOO explained the technician would review the reports with them at the end of each visit adding the previous MAD was more involved with the process. MAD and DOO both expressed any needed follow-up from the reports was Ecolab's responsibility to address adding the care center maintenance department had not acted to address any of the recommendations on the reports (dated 4/2023, 5/2023, 7/2023). However, DOO expressed they felt the mice and rodent situation at the center had "improved tremendously" from years prior.<br><br>A telephone call was placed to the EcoLab service technician on 8/3/23, with the request of a return call. However, a return call was never received.<br><br>On 8/3/23 at 11:42 a.m., an exterior tour of the care center was completed with MP-A and the MAD present. MP-A explained they tracked mouse or rodent reports using a flowsheet and, when reported, would place "sticky traps" on the patient rooms or area until the next Ecolab visit happened. MP-A verified they typically walked with the EcoLab technician and observed the areas outlined on the reports with the surveyor. The East side of the building had a large AC unit placed in the landscaping with black-colored wires running into the brick building, along with other empty holes present in the brick. MP-A observed this area and expressed it had been sealed at one time, however, the mice had "chewed it up again." MP-A stated the area did not appear sealed or patched within the past | F 925 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (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 925 | Continued From page 56<br>several months as any work the Ecolab technician completed typically was more evident and of better quality. The area next to the garbage dumpster, located outside a double door which lead into the hallway/kitchen area of the center, was then observed. A gray-colored metallic tubing was visible entering the building with a dark-gray colored material present on one-half of the hole in the brick. However, the tubing was moveable and not secured which lead to visible openings between the material and tubing. In addition, the identified area under the double doors where concrete had been worn away had a piece of steel wool shoved inside with no other visible, more permanent, sealing material present. MP-A verified they had not completed any of the repairs, as outlined the the printed Ecolab reports, as the repairs were Ecolab's responsibility adding "that's what we're paying them for."<br><br>A provided Insect and Rodent Control in the Food Service Area policy, dated 6/2016, identified the director of support services would ensure a licensed pest control performed inspections and pest control procedures on, at minimum, monthly basis. However, the policy lacked wording or dictation outlining who would make or was responsible for any needed repairs or actions. | F 925 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00993 | A. BUILDING: _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 7/31/23 to 8/3/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and | 2 000 | | |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 09/01/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00993 | A. BUILDING: _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 000 | Continued From page 1<br>identify the date when they will be completed.<br><br>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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.<br><br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.<br><br>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 | 2 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00993 | A. BUILDING: _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 000 | Continued From page 2<br>IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | 2 000 | | |
| 21015 | MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi<br><br>Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review the facility failed to ensure dishware and cooking utensils were properly sanitized (i.e., high temperature) in 1 of 1 commercial dishwashers observed in the main production kitchen. This had potential to affect all 206 residents, visitors, and staff who consumed food from the kitchen.<br><br>Findings include:<br><br>On 7/31/23 at 11:31 a.m., an initial kitchen tour was completed. A single ProPower commercial dishwasher machine was present in the kitchen and dishwasher (DW)-A was removing various items, including various dishware and cooking utensils, which had just been put through the machine for cleaning and sanitization. A series of three white-colored gauges were present on the machine which displayed wash temperature(s) and one labeled, "Final Rinse." On the soiled side of the machine (i.e., dirty), DW-B loaded another hard plastic rack with various kitchen items and loaded them into the machine for cleaning and sanitization; however, when the final rinse of the | 21015 | corrected | 8/3/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00993 | A. BUILDING: _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21015 | Continued From page 3<br><br>soiled cookware had completed the white-colored gauge displayed the final rinse temperature was only 178 F (Fahrenheit). DW-B then loaded another rack with various dishware and loaded it into the machine; however, the final rinse temperature gauge displayed the final rinse temperature as only 176 F. DW-B was interviewed and expressed they were "not sure" if the machine was a high-temperature or chemical sanitization method adding nobody had ever directed or instructed them to check the gauges on the machine during the wash and rinse cycles. DW-B added they knew "nothing about the gauges." DW-A continued to remove the cleaned items and place them back in shelving and cupboards for future use.<br><br>On 8/2/23 at 8:38 a.m., a subsequent kitchen tour was completed. The same commercial dishwasher was in use with food service worker (FSW)-A loading various dishware and cooking utensils into the machine for cleaning. The machine completed the wash cycle and then activated the final rinse, however, the final rinse temperature displayed on the analog gauge was only 175 F. FSW-A loaded another rack with other, soiled kitchenware and dishware items and placed it into the machine. However, again, the final rinse temperature displayed on the gauge was 175 F. FSW-A was interviewed and expressed they were unsure if the machine was a high temperature or chemical sanitization method adding, "That's a good question." FSW-A then left the dishwasher area and returned with the food service manager (FSM) who reviewed the machine. FSM verified the dishwasher was a high-temperature sanitization method and the white-colored gauges were the ones used to monitor and check the machine' function. FSM then loaded a rack with soiled silverware and an | 21015 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00993 | A. BUILDING: _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21015 | Continued From page 4<br><br>empty silverware basin and ran it through the machine, however, the final rinse temperature only recorded 174 F which FSM verified. FSM stated the final rinse cycle should be reaching 180 F to ensure the dishware was properly cleaned adding the machine had not been serviced "in awhile" but was due. FSM explained the staff had been using "test strips" on various loads to ensure it was reaching proper temperature, and retrieved these strips from the dining room before handing them to the surveyor. FSM stated they tested the machine using these strips on a weekly basis.<br><br>A package of orange-colored Taylor test strips were provided with directions to attach a test strip to a utensil or rack and washing the items with the strip attached. It directed, "If the color bar has turned bright orange, the dishwasher is maintaining the proper temperature." These strips were removed and were orange-colored with large font present reading, "180 F," and, "Pass When Blue Bar Turns Orange."<br><br>At 8:58 a.m., the food service director (FSD) joined the interview and demonstration of the dishwasher. A test strip was attached to a metallic utensil and ran through the machine on a rack. The final rinse, again, did not hit 180 F and the attached strips remained with a blue-tint upon exiting the machine. FSD stated they believed the machine to be functioning correctly and hitting the correct temperature adding the issue was "more than likely the gauge" being incorrect. A three compartment sink was adjacent to the dishwasher machine which FSD stated used the same hot water lines which fed the dishwasher. A new test strip was placed under the running hot water of the three compartment sink, and the strip turned orange with no blue-tint present on the | 21015 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00993 | A. BUILDING: _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21015 | Continued From page 5<br><br>strip as had been the result when ran through the dishwasher. FSD acknowledged the strip color difference between the two but expressed they felt it was only "faintly" different adding the test strips used for quality monitoring on the dishwasher were not saved and immediately discarded.<br><br>A clipboard with a Dish Machine Temperature Log, dated 8/2023, flow sheet attached was then provided. The flow sheet identified a series of rows and columns which provided space to recorded the wash temperature, rinse temperature, and initials of staff recording the data for three meals on each respective calendar day with the third meal labeled, "Dinner," including an additional column labeled, "Surface Temp Reading." The rinse column identified the temperature should be, "min[imum] of 180," and all the recorded temperatures ranged 180-181 F. The only recorded surface temperature was listed as, "160." An additional Dish Machine Temperature Log, dated 7/2023, flow sheet was included outlined the same series of rows and columns to record the data for the machine. The final rinse column recorded temperatures which ranged 180 F to 182 F, and the surface temperatures recorded ranged from 155 F to 181 F.<br><br>FSD stated they had not been told and were unaware of any concerns with the commercial dishwasher not getting to 180 F during the final rinse cycle, but expressed it was important the machine did to "kill the bacteria and germs" which could remain on the dishware and cooking items. FSD reiterated the 180 F temperature importance, and stated a company was scheduled to review the dishwasher the same day (8/2/23) as the machine had developed some | 21015 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00993 | A. BUILDING: _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21015 | Continued From page 6<br><br>"sheeting" and was not removing rinse aide correctly which resulted in spotting on some pans and dishware. FSD stated the machine was supposed to be serviced every four months, however, had not been serviced in "seven [or] eight months" now due to the outside company having various issues.<br><br>When interviewed on 8/2/23 at 9:43 a.m., the registered dietician (RD) explained the facility' dishwasher was a high-temperature sanitization machine, and it had "been on our radar off and on" for several months due to the gauges potentially not reading correctly. RD stated the water entering the machine was kept at 180 F so they were not sure how the temperature could be falling out of range. RD explained they were onsite at the center the previous week and, at the time, the machine had been hitting the temperatures required (i.e., 180 F). RD stated they would recommend the machine, including the gauges, be inspected to ensure proper function adding they didn't realize the machine had been "temping out that low" as the surveyor observation. RD verified the test strips being used (i.e., Taylor) should turn bright orange if the temperature was obtained and FSD had also been testing the surface temperature of various dishware to ensure the rack level minimum temperature (i.e., 160 F) was obtained on the final rinse cycle. RD verified the final rinse cycle should be hitting 180 F (via gauge) or 160 F (via rack level) as "that's when the sanitization happens" to reduce the risk of foodborne illness adding, "It's clearly an important step."<br><br>On 8/2/23 at 1:29 p.m., a return visit to the kitchen was completed with FSD and FSM present. FSD verified they had been testing the surface temperature (i.e., rack level) of the | 21015 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00993 | A. BUILDING: _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21015 | Continued From page 7<br><br>machine and retrieved a handheld yellow-colored, infrared-style thermometer from the dining room area. A metallic pan was then loaded into a rack and ran through the dishwasher with the gauge labeled, "Final Rinse," again only hitting 175 F. Immediately as the metallic pan emerged from the dishwasher, FSD then used the thermometer to check the surface temperature of the dishware which resulted, "156 [F]," at the highest point. FSD verified the surface temperature did not hit, at minimum, the 160 F to demonstrate proper rack level rinse temperature.<br><br>A provided Cleaning and Sanitizing Food Contact Surfaces policy, undated, identified a purpose of preventing foodborne illness by ensuring all food contact surfaces were properly cleaned and sanitized. A section labeled, "6. If a dishmachine is used," directed to check with the manufacturer to ensure the data plate (i.e., gauges) was correct and to use the data plate to determine wash and final rinse temperatures, if applicable. Further, the policy outlined, "Ensure that food contact surfaces reach a surface temperature of 160 F or above if using hot water to sanitize."<br><br>SUGGESTED METHOD OF CORRECTION: The director of culinary, or designee, could ensure any needed repairs are made to the dishwasher to ensure proper final rinse temperature of, at minimum, 180 F is attained during the wash cycles. They could then audit to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one days | 21015 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00993 | A. BUILDING: _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21225 | Continued From page 8 | 21225 | | |
| 21225 | MN Rule 4658.0700 Subp. 2 A Medical Director; Duties Develop res care P&P<br><br>Subp. 2. Duties. The medical director, in conjunction with the administrator and the director of nursing services, must be responsible for:<br>A. the development of resident care policies and procedures that are to be approved by the licensee;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review the facility failed to ensure the medical director (MD), who was a psychiatrist, actively participated in the development, implementation, and review of policies and procedures related to resident medical care. This had the potential to affect all 206 residents residing in the facility.<br><br>Findings include:<br><br>During an interview on 8/3/23 at 10:21 a.m., the assistant director of nursing (ADON) stated each resident had their own psychiatrist for mental health treatment and their own primary provider for medical care. ADON further stated, due to the facility being classified as a Mental Health Institute (MHI), although they were licensed as a nursing facility, the facility did not allow any providers to come into the facility to provide care and/or assessments to residents because the expense would not be covered by Medicaid. The ADON stated the facility tried to make appointments for the residents to see their personal psychiatrist every 60 days for their mental health and attempted to get into contact with their primary provider for their medical | 21225 | corrected | 10/15/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00993 | A. BUILDING: _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21225 | Continued From page 9<br><br>conditions; however, they did not always get a response from the primary providers.<br><br>During an interview on 8/3/23 at 1:45 p.m., the director of clinical services (DCS) stated the facility medical policies were created many years ago when the medical director of the facility was both an internist (medical physician) and a psychiatrist. The DCS stated the director of nursing (DON) and other non-physician staff reviewed the policies to ensure they were consistent with the "regulations." The DCS further stated if a policy or procedure that was out of their "scope" needed to be updated, the facility would "try to find someone" to review it, but the DCS was unsure who that would be. The DCS verified the facility medical director was not involved in the review of policies and procedures related to the medical care of the residents.<br><br>During an interview on 8/2/23 at 2:28 p.m., the consulting pharmacist (CP) stated because the resident's all had their own primary care provider (PCP), she often did not get a response to her recommendations and therefore, only made medication recommendations once a year. If the CP made a recommendation, she would set a reminder for herself in six months to review the resident's chart to see if the recommendations were addressed. The CP further stated some physicians were "completely unresponsive," and the facility had never found a "good way to follow up."<br><br>During an interview on 8/3/23 at 1:06 p.m., the administrator stated because the facility was an MHI, providers could not go into the facility to see the residents. The administrator stated after hours, staff would attempt to call the resident's PCP, however, it was very difficult to get a call | 21225 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00993 | A. BUILDING: _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21225 | Continued From page 10<br><br>back "timely." The administrator stated staff could also call the MD who would attempt to get ahold of the resident's PCP also. The administrator further stated if staff were unable to contact the PCP or their on-call provider, the resident would be sent to the emergency department.<br><br>During and interview on 8/3/23 at 1:35 p.m. the MD stated because the facility was designated a MHI, no care providers were able to go into the facility and therefore, all residents had their own psychiatrist who handled their mental health and a separate primary care provider (PCP) who handled the resident's medical conditions. The MD stated all PCPs had 24 on-call services the staff could contact in the event of a medical emergency; however, "many" psychiatrists do not have 24 hour availability; therefore the staff could call the MD 24 hours a day and she would help them "problem solve." The MD stated if she was unable to "problem solve" with the staff, the resident could wait until the following day, or the staff could send the resident to the emergency department. The MD stated in a "very rare case" she may refill a psychiatric medication over the weekend, but she only provided consultation to staff regarding resident psychiatric care. The MD stated she did not provide medical care for the residents and was not involved in the development of any medical policies or procedures such as diabetic or seizure care; and did not know who was.<br><br>Review of the facility seizure procedure dated 2/11/02, indicated any resident who had a seizure would be monitored for 24 hours. Residents requiring more acute medical attention would be sent to the emergency department for evaluation. The procedure also indicated residents with a seizure disorder were to use a shower rather than | 21225 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00993 | A. BUILDING: _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21225 | Continued From page 11<br><br>a tub for hygiene. If a tub was necessary, the resident would be monitored in the tub if bathing assistance was needed; otherwise, staff were to sit outside the tub room. No further interventions regarding the treatment of a resident having a seizure was documented, including maintaining a resident's airway, lowering them to the ground for safety, measures to ensure the resident did not aspirate during seizure activity, or the administration of oxygen.<br><br>SUGGESTED METHOD OF CORRECTION: The Governing Body or designee could review and revise policies and procedures on how the medical director could effectively provide physician oversight to ensure appropriate resident care occured and have a method of monitoring compliance. The Governing Body or designee could develop a system to ensure the medical director was actively involved in the development, implementation and review of facility policies and procedures regarding resident medical care to ensure residents received appropriate medical care according to professional standards of practice.<br><br>TIME PERIOD FOR CORRECTION: Twenty One (21) days | 21225 | | |
| 21675 | MN Rule 4658.1410 Linen<br><br>Nursing home staff must handle, store, process, and transport linens so as to prevent the spread of infection according to the infection control program and policies as required by part 4658.0800. These laundering policies must comply with the manufacturer's instructions for the laundering equipment and products and | 21675 | | 9/9/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00993 | A. BUILDING: _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21675 | Continued From page 12<br><br>include a wash formula addressing the time, temperature, water hardness, bleach, and final pH.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review the facility failed to show proper infection control processes were in place when visibly soiled personal laundry was left unattended on top of a communal washing machine. This had the potential to affect all 206 residents residing in the facility with access to the washing machine.<br><br>Findings include:<br><br>During observation and interview on 8/2/23 at 8:10 a.m., the 2nd floor locked laundry room contained two stackable washer and dryer units. Approximate dimensions of laundry room was five feet by five feet. On top of washing machine labeled, "#1" was a pile of visibly soiled personal laundry. On the very top of the pile of laundry was one blue undergarment with three visibly dried dark red stains that included the elastic of both leg openings into the crotch panel. To the right of this was a blue leopard print undergarment with dried dark amber colored stain of crotch panel. On the floor of the laundry room was another light dusty rose colored undergarment with dried dark yellow stained crotch panel. During interview with social services (SS)-A stated "dirty linen should not be here on the unit and left". SS-A stated the laundry room is shared by all the residents and soiled linen is "not sanitary".<br><br>During interview with facility infection control preventionist (IP) on 8/2/23 at 10:47 a.m., IP stated laundry procedures with residents are | 21675 | corrected | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00993 | A. BUILDING: _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21675 | Continued From page 13<br><br>reviewed upon admission to the facility. IP stated visibly dirty laundry "should never be left unattended" in the unit laundry rooms due to infection control risk. IP stated soiled or dirty laundry can cause outbreaks in this facility". IP stated new admissions are instructed on facility laundry procedures and expectations.<br><br>R143's quarterly Minimum Data Set (MDS) dated, 5/10/23, indicated intact cognition.<br><br>During interview with R143 on 8/2/23 at 12:26 p.m., R143 stated she was informed on admission to facility on expectations of residents to perform their own laundry. R143 stated, "I cannot leave my dirty laundry unattended. You can't put it up there (pointing to the washing machine lid) and leave".<br><br>During interview with program director (PD) on 8/2/23 at 1:45 p.m., PD stated, "there should never be soiled personal laundry sitting on top of the washer machine because it is communally used and is a risk for infection". PD stated the facility uses a checklist for all new residents to explain to them the process and expectation of doing their personal laundry.<br><br>During interview with facility's maintenance director (MAD) on 8/3/23 at 8:46 a.m., MAD stated the expectation was soiled personal laundry should not be allowed to be left out. "It is not ok."<br><br>Form titled, Resident Orientation Checklist dated 3/20/23 stated day 5 is when Laundry Procedures: 1. Linen Day, 2. Use of floor washing machines, 3. Use of Andrew laundry services is reviewed with all new admissions. Form titled Resident Use of Floor Laundry Facilities dated | 21675 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00993 | A. BUILDING: _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21675 | Continued From page 14<br>6/22/09 stated, "7. Each resident is expected to leave the Laundry Room and the laundry facilities clean and in order..."<br><br>SUGGESTED METHOD OF CORRECTION: The administrator, or designee, could review applicable policies on personal linen handling; then then inservice appropriate staff and audit to ensure ongoing compliance.<br><br>TIME FRAME FOR CORRECTION: Twenty-one (21) Days | 21675 | | |
| 21730 | MN Rule 4658.1415 Subp. 11 Plant Housekeeping, Operation, & Maintenance<br><br>Subp. 11. Insect and rodent control. Any condition on the site or in the nursing home conducive to the harborage or breeding of insects, rodents, or other vermin must be eliminated immediately. A continuous pest control program must be maintained by qualified personnel.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure structural repair recommendations from an outside pest control contractor were acted upon and completed timely to reduce the risk of rodent or pest entrance into the care center. This had potential to affect all 206 residents, visitors and staff at the facility.<br><br>Findings include:<br><br>A Centers for Disease Control (CDC) How to | 21730 | corrected | 9/1/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00993 | A. BUILDING: _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21730 | Continued From page 15<br><br>Control Wild Rodent Infestations article, dated 1/2023, identified rats and mice were known to carry various diseases which could be spread to a human population. These diseases included salmonellosis, monkeypox, and tularemia. Further, the article outlined it was important to seal gaps or holes in exterior walls adding, "mice can fit through a hole the width of a pencil (1/4 inch or 6 millimeters in diameter)."<br><br>R106's annual Minimum Data Set (MDS), dated 5/26/23, identified R106 had intact cognition. On 7/31/23 at 1:58 p.m., R106 was interviewed and expressed the care center had "a little bit of a mouse problem." R106 explained they had seen mice within the nursing home, off and on, for a "couple months" including within the dining room which was next to the kitchen. R106 stated they thought the home had brought in an outside company to help address the issue, and explained even the food service director (FSD) had reported they turn the lights on in the dining room and the mice "just scatter" in the early morning hours. R106 stated they felt the issue had resolved until just last week when another female in the home screamed aloud they had "saw a mouse" run into the kitchen from the dining room.<br><br>R165's quarterly MDS, dated 7/15/23, identified R165 had intact cognition. On 7/31/23 at 2:29 p.m., R165 was interviewed. R165 stated the care center had mice and, as a result, they had several traps present within their room. R165 stated they had reported mice activity to the maintenance department who, in turn, then placed additional traps in their room but expressed nothing else about plans to correct the issue. | 21730 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00993 | A. BUILDING: _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21730 | Continued From page 16<br><br>When interviewed on 8/3/23 at 8:19 a.m., living skills instructor (LSI)-A stated a male resident on the 2nd floor had reported a mouse in their room just a day or two prior, which had been reported to the maintenance department. LSI-A stated they had not noticed or heard of concerns with mice or rodents prior.<br><br>On 8/3/23 at 8:26 a.m., mental health worker (MHW)-A was interviewed, and expressed they had never personally observed mice or rodents at the center, however, residents had complained about them off and on adding they had last heard a complaint a few months prior. MHW-A stated the maintenance department would be notified of any such complaints and then it was "in their hands after that."<br><br>When interviewed on 8/3/23 at 8:30 a.m., FSD stated they had seen mice in the dining room area but felt it had "been awhile," adding the last time was "at least a month ago." FSD stated the maintenance department was aware of the issue and, as a result, had EcoLab (an outside company) coming in and addressing it to their knowledge.<br><br>On 8/3/23, the reports from the outside pest control agency were requested and a blue-colored binder was provided. Inside, a series of paperwork was identified for each month work and/or inspection had been completed. These included:<br><br>A printed Ecolab Customer Service Report, dated 4/25/23, identified the care center was serviced and listed a section, "Pest Activity Found," which outlined no rodent activity had been located adding, "Spoke with and showed [Jason] structural concerns and findings related to rodent | 21730 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00993 | A. BUILDING: _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21730 | Continued From page 17<br><br>activity ... informed me of rodent catches in patient rooms and sightings in kitchen/dining area." A section was labeled, "Structural Concerns," which outlined a hole/gap was located around the wires entering the building for ventilation and fans on the East side of the building adding, "Gaps are large enough for rodent entry. Please seal to prevent pest entry." A corresponding column labeled, "Action Taken/Needed," identified, "Seal to prevent pest entry ... will reduce the numbers of pests entering the area." The report was signed by both the EcoLab service technician and maintenance personnel (MP)-A.<br><br>An additional printed EcoLab Customer Service Report, dated 5/16/23, identified the care center was again serviced and listed a section, "Pest Activity Found," which identified rodent activity was found in the exterior of the building, inside a storage room, and in the ceilings. The section labeled, "Structural Concerns," identified a hole/gap on the East side of the building was identified surrounding the area where air conditioning (AC) hoses entered the building, and a gap under the double doors by the garbage area which lead into the building. The report directed both areas should be sealed to prevent rodent entry and harborage. The report was signed by both the EcoLab service technician and maintenance personnel (MP)-A.<br><br>Further, a subsequent Ecolab Customer Service Report, dated 7/13/23, identified the care center was serviced and listed a section, "Pest Activity Found," which outlined mice had been found in exterior stations (i.e., traps). These traps were inspected and serviced. The section labeled, "Structural Concerns," outlined a hole/gap was found near the wall/ground junction on the | 21730 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00993 | A. BUILDING: _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21730 | Continued From page 18<br><br>northeast side of building between the AC unit and side door into the center. The area was treated and "temporarily sealed" with added dictation, "Please seal hole with more permanent material." The corresponding area marked, "Action Needed/Taken," outlined, "Seal to prevent pest entry or harborage ... measures here will reduce the number of pests entering the area." The report continued and another concern was listed which outlined a hole/gap was located in the back of the building next to the garbage area at the right base of the double doors entering the care center due to worn away concrete. This area was also treated and "temporarily sealed" which dictation present, "Please seal permanently." The report was signed by both the EcoLab service technician and maintenance personnel (MP)-A.<br><br>On 8/3/23 at 10:55 a.m., the maintenance director (MAD) and director of operations (DOO) were interviewed. MAD stated they had just started working the center about two months prior, and MP-A would likely the best person to visit with about follow-up to the printed Ecolab reports as they had typically walked with the technician for each visit. DOO stated there had been a "more expansive" issue with mice and rodents during the pandemic as residents were eating more in their rooms. As a result, they had a building walk-through with an outside pest control agency who, at that time, helped seal up various openings and fix identified structural concerns. DOO explained the technician would review the reports with them at the end of each visit adding the previous MAD was more involved with the process. MAD and DOO both expressed any needed follow-up from the reports was Ecolab's responsibility to address adding the care center maintenance department had not acted to address any of the recommendations on the | 21730 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00993 | A. BUILDING: _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21730 | Continued From page 19<br><br>reports (dated 4/2023, 5/2023, 7/2023). However, DOO expressed they felt the mice and rodent situation at the center had "improved tremendously" from years prior.<br><br>A telephone call was placed to the EcoLab service technician on 8/3/23, with the request of a return call. However, a return call was never received.<br><br>On 8/3/23 at 11:42 a.m., an exterior tour of the care center was completed with MP-A and the MAD present. MP-A explained they tracked mouse or rodent reports using a flowsheet and, when reported, would place "sticky traps" on the patient rooms or area until the next Ecolab visit happened. MP-A verified they typically walked with the EcoLab technician and observed the areas outlined on the reports with the surveyor. The East side of the building had a large AC unit placed in the landscaping with black-colored wires running into the brick building, along with other empty holes present in the brick. MP-A observed this area and expressed it had been sealed at one time, however, the mice had "chewed it up again." MP-A stated the area did not appear sealed or patched within the past several months as any work the Ecolab technician completed typically was more evident and of better quality. The area next to the garbage dumpster, located outside a double door which lead into the hallway/kitchen area of the center, was then observed. A gray-colored metallic tubing was visible entering the building with a dark-gray colored material present on one-half of the hole in the brick. However, the tubing was moveable and not secured which lead to visible openings between the material and tubing. In addition, the identified area under the double doors where concrete had been worn | 21730 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00993 | A. BUILDING: _____ B. WING _____ | C 08/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ANDREW RESIDENCE | 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21730 | Continued From page 20<br><br>away had a piece of steel wool shoved inside with no other visible, more permanent, sealing material present. MP-A verified they had not completed any of the repairs, as outlined the the printed Ecolab reports, as the repairs were Ecolab's responsibility adding "that's what we're paying them for."<br><br>A provided Insect and Rodent Control in the Food Service Area policy, dated 6/2016, identified the director of support services would ensure a licensed pest control performed inspections and pest control procedures on, at minimum, monthly basis. However, the policy lacked wording or dictation outlining who would make or was responsible for any needed repairs or actions.<br><br>SUGGESTED METHOD OF CORRECTION: The director of maintenance, or designee, could review applicable policies and educate staff to ensure needed building repairs are made timely to reduce the risk of rodent infestation; then audit to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one days | 21730 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **08/02/2023** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ANDREW RESIDENCE** | **1215 SOUTH 9TH STREET**<br>**MINNEAPOLIS, MN 55404** |

| (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<br><br>FIRE SAFETY<br><br>An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/02/2023. At the time of this survey, Andrew Residence was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.<br><br>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.<br><br>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.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. | K 000 | | |

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

Electronically Signed | 09/01/2023

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 |
|---|---|---|---|
| | 24E116 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **08/02/2023** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ANDREW RESIDENCE** | **1215 SOUTH 9TH STREET**<br>**MINNEAPOLIS, MN 55404** |

| (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 | K 000 | | |

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

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

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

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

Andrew Residence is a five-story building with a full basement that was built in 1973, with an addition in 1978, and was determined to be of Type II(222) construction. The entire building is protected with a complete automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The facility has a fire alarm system with resident room detectors, corridor smoke detection, and in common areas that are on the fire alarm system. The fire alarm system is monitored for automatic

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **08/02/2023** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ANDREW RESIDENCE** | **1215 SOUTH 9TH STREET**<br>**MINNEAPOLIS, MN 55404** |

| (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 2<br>fire department notification.<br><br>The facility has a capacity of 212 beds and had a census of 200 at the time of the survey.<br><br>The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: | K 000 | | |
| K 341<br>SS=F | Fire Alarm System - Installation<br>CFR(s): NFPA 101<br><br>Fire Alarm System - Installation<br>A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity.<br>18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to install the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1 and 9.6.1.3, and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, section 17.14.4. This | K 341 | The Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency exists or that the statement of | 11/1/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **08/02/2023** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ANDREW RESIDENCE** | **1215 SOUTH 9TH STREET**<br>**MINNEAPOLIS, MN 55404** |

| (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 341 | Continued From page 3<br>deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 08/02/2023 between 09:00 AM and 12:00 PM, it was revealed by observation that besides the fire alarm pull stations located at the nurse's stations the majority of the fire alarm pull stations located in the facility were installed higher than the maximum height of 48 inches above floor level.<br><br>An interview with the Executive Director, Director of Support Services, Maintenance Supervisor, and Maintenance Engineer verified this deficient finding at the time of discovery. | K 341 | deficiency was correctly cited or factually based, and it is also not to be construed as an admission against interest of the facility, the administrator or any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same.<br>All fire alarm pull-stations currently installed at the incorrect height will be moved to the proper height.<br>On August 4, 2023, the Fire and Safety Director contacted Johnson Controls, the contractor for the Fire Alarm System, to alert them that we will need their service to re-locate fire alarm pull stations.<br>On August 24, 2023, an on-site assessment of the number of and location of the improperly installed fire alarm pull-stations was conducted by a technician from Johnson Controls to assess the scope of the project. The facility has authorized Johnson Controls to move ahead as soon as possible to relocate the pull-stations and is awaiting notice of the scheduled date.<br>The facility will notify the State Fire Marshal's Office when the work for moving the fire alarm pull stations is scheduled. The facility will also notify the State Fire Marshal's Office when the work is completed.<br>After completion the Fire and Safety Director shall visually inspect all the fire alarm pull stations to ensure that they have been correctly installed. The results of the visual inspection will be discussed and noted in the monthly Safety/Risk Management Committee. The Fire and | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **08/02/2023** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ANDREW RESIDENCE** | **1215 SOUTH 9TH STREET**<br>**MINNEAPOLIS, MN 55404** |

| (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 341 | Continued From page 4 | K 341 | Safety Director will make a verbal report to the Quarterly QAPI committee.<br>The Facility Administrator is ultimately responsible for maintaining compliance, delegating responsibility to the Fire and Safety Director.<br>Date of completion:11/1/2023 | |
| K 741<br>SS=D | Smoking Regulations<br>CFR(s): NFPA 101<br><br>Smoking Regulations<br>Smoking regulations shall be adopted and shall include not less than the following provisions:<br>(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.<br>(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.<br>(3) Smoking by patients classified as not responsible shall be prohibited.<br>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.<br>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.<br>(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.<br>18.7.4, 19.7.4<br><br>This REQUIREMENT is not met as evidenced | K 741 | | 9/9/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **08/02/2023** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ANDREW RESIDENCE** | **1215 SOUTH 9TH STREET**<br>**MINNEAPOLIS, MN 55404** |

| (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<br>by:<br>Based on observation and staff interview, the facility failed to maintain the designated resident smoking area per NFPA 101 (2012 edition), Life Safety Code, section 19.7.4. This deficient finding could have an isolated impact on the residents within the facility.<br><br>Findings include:<br><br>On 08/02/2023 at 11:32 AM, it was revealed by observation that there were discarded cigarettes found mixed with combustibles in two trash cans located in the resident's smoking area outside the building.<br><br>An interview with the Executive Director, Director of Support Services, Maintenance Supervisor, and Maintenance Engineer verified this deficient finding at the time of discovery. | K 741 | The Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency exists or that the statement of deficiency was correctly cited or factually based, and it is also not to be construed as an admission against interest of the facility, the administrator or any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same.<br><br>The facility removed the non-compliant trash containers and replaced them with non-combustible trash containers. The replacement trash containers were labeled “Trash Only-No Cigarette Butts”. Metal topped Ash Trays with a metal container for cigarette butts are placed on tables throughout the west-side smoking patio. Additionally, there are 6 floor-mounted metal ash trays where the top containing used cigarette butts can be removed and the cigarette butts can be deposited into a non-combustible base. A small metal trashcan labeled CIGARETTE BUTTS ONLY was placed on the smoking patio on August 4, 2023, as an interim measure.<br>Three 21-gal Stainless Steel Swing-Top Trash Cans featuring “flame-out” design were ordered. The scheduled delivery date is between September 5-7, 2023. These containers will be labeled “Cigarette Butts Only, No Trash”. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **08/02/2023** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ANDREW RESIDENCE** | **1215 SOUTH 9TH STREET**<br>**MINNEAPOLIS, MN 55404** |

| (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 6 | K 741 | The patio area is maintained on a regular basis by the maintenance staff. The maintenance staff have been trained to inspect the trash container to ensure that there are no cigarette butts mixed in with the trash, and that no trash is mixed in with the cigarette butts in the designated cigarette butt containers. If a mixture of trash and cigarette butts is found residents will be re-educated as to the proper disposal of smoking material through reminder posters, and discussion facilitated by staff in regularly scheduled floor meetings and Resident Council Meetings.<br>On-going compliance will be maintained by ensuring only proper containers are placed on the west patio, the only designated area of the facility where residents are permitted to smoke. A monthly report will be made to the Safety/Risk Management Committee with a notation in the meeting minutes. The Fire and Safety Director will also report to the quarterly QAPI meeting to track compliance.<br>The Facility Administrator is ultimately responsible for maintaining compliance, delegating responsibility to the Fire and Safety Director.<br>Completion date: 9/9/2023 | |
| K 901<br>SS=F | Fundamentals - Building System Categories<br>CFR(s): NFPA 101<br><br>Fundamentals - Building System Categories<br>Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and | K 901 | | 8/30/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **08/02/2023** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ANDREW RESIDENCE** | **1215 SOUTH 9TH STREET**<br>**MINNEAPOLIS, MN 55404** |

| (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 901 | Continued From page 7<br>documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to provide a Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 08/02/2023 between 09:00 AM and 12:00 PM, it was revealed by a review of available documentation that the facility could not provide an NFPA 99 utility risk assessment at the time of survey.<br><br>An interview with the Executive Director, Director of Support Services, Maintenance Supervisor, and Maintenance Engineer verified this deficient finding at the time of discovery. | K 901 | The Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency exists or that the statement of deficiency was correctly cited or factually based, and it is also not to be construed as an admission against interest of the facility, the administrator or any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same.<br>The facility completed a risk assessment per NFPA 99 (2012 edition) Heath Care Facilities Code, section 4.2 utilizing the forms recommended by the State Fire Marshal's Office. This assessment was completed by the Fire and Safety Director and the Director of Nursing Servicing Services in conjunction with the maintenance staff on August 30, 2023. This assessment will be added to the most recent annual revision of NFPA 99 completed on May 17, 2023.<br>Ongoing compliance with NFPA 99, (2012 edition). Health Care Facilities Code 4.2 will be maintained by conducting an assessment annually. Documentation of | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **08/02/2023** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ANDREW RESIDENCE** | **1215 SOUTH 9TH STREET**<br>**MINNEAPOLIS, MN 55404** |

| (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 901 | Continued From page 8 | K 901 | the completed assessment will be maintained in the facility documents and will be made available to the appropriate agencies as requested. The Fire and Safety Director maintains a checklist showing what fire and safety tasks are to be completed each month. Review of Emergency Preparedness and completion of the NFPA 99 (Annual) risk assessment is on the checklist for April.<br>The Facility Administrator is ultimately responsible for maintaining compliance, delegating responsibility to the Fire and Safety Director. | |
| K 918<br>SS=F | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>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.<br>Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.<br>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 | K 918 | | 8/29/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING **01 - MAIN BUILDING 01** B. WING _____ | **08/02/2023** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ANDREW RESIDENCE** | **1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404** |

| (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 9<br>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, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to test the Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.9, 8.4.9.1, and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 08/02/2023 between 09:00 AM and 12:00 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that they have completed a four-hour test of the generator within the last 36 months.<br><br>An interview with the Executive Director, Director of Support Services, Maintenance Supervisor, and Maintenance Engineer verified this deficient finding at the time of discovery. | K 918 | The Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency exists or that the statement of deficiency was correctly cited or factually based, and it is also not to be construed as an admission against interest of the facility, the administrator or any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same.<br>The facility maintenance staff has maintained ongoing completion and documentation of the required weekly and monthly testing of the Emergency Power Supply System (EPSS). The facility has also maintained an annual service agreement with an external power systems contractor to ensure that the EPSS is operating effectively and efficiently. Included in this annual service | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **08/02/2023** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ANDREW RESIDENCE** | **1215 SOUTH 9TH STREET**<br>**MINNEAPOLIS, MN 55404** |

| (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 10 | K 918 | agreement has been a two-hour power systems load test ensuring the operational effectiveness of the equipment.<br>The Facility contracted with Zeigler Inc. (Power Systems Contractor), on August 23, 2023, and scheduled a four-hour power systems load test to meet the code requirements indicated above. This four-hour test was completed on August 29, 2023, and documentation verifying the test will be retained by the Environmental Services Director/Fire and Safety Director.<br>To assure compliance is maintained the Fire and Safety Director will note that another four-hour generator test must be completed on or before August 23. 2026.<br>The Facility Administrator is ultimately responsible for maintaining compliance, delegating this responsibility to the Fire and Safety Director | |

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
November 8, 2023

Administrator
Andrew Residence
1215 South 9th Street
Minneapolis, MN  55404

RE: CCN: 24E116
Cycle Start Date: August 3, 2023

Dear Administrator:

On August 25, 2023, we notified you a remedy was imposed. On October 26, 2023 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 1, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 9, 2023 be discontinued as of November 1, 2023. (42 CFR 488.417 (b))

In our letter of August 25, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 9, 2023. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered

November 8, 2023

Administrator
Andrew Residence
1215 South 9th Street
Minneapolis, MN  55404

Re: Reinspection Results
Event ID:  CJQ312

Dear Administrator:

On October 26, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 3, 2023.  At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us