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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: DVXB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00993

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E116**
2.STATE VENDOR OR MEDICAID NO.
(L2) **201955800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ANDREW RESIDENCE**
(L4) **1215 SOUTH 9TH STREET**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/18/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **212** (L18)
13.Total Certified Beds **212** (L17)

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		212		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Sandra Tatro, HFE-NE II 05/21/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kami Fiske, Certification Specialist 05/21/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/31/1974
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 24E116
March 27, 2018

Mrs. Karen Foy, Administrator
Andrew Residence
1215 South 9th Street
Minneapolis, MN 55404

Dear Mrs. Foy:

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

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

Effective December 22, 2018 the above facility is certified for:

212 Nursing Facility II Beds

Your facility's Medicare approved area consists of all 212 nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered

March 27, 2018

Mrs. Karen Foy, Administrator
Andrew Residence
1215 South 9th Street
Minneapolis, MN 55404

RE: Project Number SE116026

Dear Mrs. Foy:

On August 16, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 2, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 12, 2017 a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies at the time of the FMS were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required. On September 25, 2017 CMS forwarded the results of the LSC FMS and notified you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and that they were imposing the following enforcement remedy:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 2, 2017. (42 CFR 488.417(b)).

Also, the CMS Region V Office notified you in their letter of September 25, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility would be prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 2, 2017.

On September 18, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 22, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 2, 2017 and the FMS survey completed on September 12, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 31, 2017. Based on our PCR, we have determined that your facility has

corrected the deficiencies issued pursuant to our standard survey, completed on August 2, 2017 and the FMS survey completed on September 12, 2017, and therefore remedies outlined in our letter to you dated August 16, 2017, will not be imposed.

Your request for a temporary waiver involving the deficiencies cited under K161 and K521 at the time of the August 2, 2017 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 27, 2018

Mrs. Karen Foy, Administrator
Andrew Residence
1215 South 9th Street
Minneapolis, MN 55404

Re: Reinspection Results - Project Number SE116026

Dear Mrs. Foy:

On September 18, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 2, 2017, with orders received by you on August 16, 2018. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DVXB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00993

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E116**

2.STATE VENDOR OR MEDICAID NO.
(L2) **201955800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ANDREW RESIDENCE**
(L4) **1215 SOUTH 9TH STREET**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/02/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **212** (L18)

13.Total Certified Beds **212** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		212		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Amy Charais, HFE-NE II 08/29/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Specialist 09/05/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/31/1974
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DVXB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00993

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/02/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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7. PROVIDER/SUPPLIER CATEGORY **10** (L7)

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04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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From (a) :
To (b) :

12.Total Facility Beds **212** (L18)
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Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		212		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Amy Charais, HFE-NE II — 08/29/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Joanne Simon, Certification Specialist — 09/05/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
03/31/1974
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
9/12/17 (L33)

DETERMINATION APPROVAL

Electronically delivered
August 16, 2017

Mrs. Karen Foy, Administrator
Andrew Residence
1215 South 9th Street
Minneapolis, MN 55404

RE: Project Number SE116026

Dear Mrs. Foy:

On August 2, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: gloria.derfus@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 11, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 11, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 2, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
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cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E116	A. BUILDING _____ B. WING _____	08/02/2017

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	INITIAL COMMENTS On July 31, August 1, & 2, 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The	F 166		9/11/17

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

Electronically Signed | 08/24/2017

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

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grievance policy must include:

(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately

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F 166	Continued From page 2 reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the resolution of grievances in a timely manner for 1 of 1 resident (R175) reviewed who had filed a grievance with the facility.	F 166	The subject of resident 175's grievance had been discharged from the facility at the time of the survey. While resident 175 has indicated a desire to move to an alternative setting, she has declined to release information requested to facilitate	

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F 166	Continued From page 3 Findings include: R175's Quarterly Minimum Data Set (MDS) indicated she had intact cognition. R175's care plan dated 3/27/17 identified psychiatric symptoms that impair judgement and functioning. During an interview on 8/1/17, at 3:34 p.m. R175 approached survey team and identified the following concern: R175 stated on or around Memorial Day weekend of 2017 another resident in the facility threw a walker at her and ripped a bulletin board off the wall. She stated the other resident was removed from the facility but then returned a few days later. R175 stated upon his return he was placed in a room right across the hall from her and stated it made her anxious. She stated she felt like she was the one being punished. R175 further stated she was not aware of a grievance process but talked to staff when she had concerns. A review of a facility Interdisciplinary Progress Notes identified the following: - 5/19/17 Writer met with R175 to discuss the people who live on the same floor as she does. "These people cause her to feel unsafe when she is in her room." - 5/23/17 Writer met with R175 to discuss her request for a discharge. R175 explained to writer she had been involved in a situation over the weekend that "scared her to the point where she does not want to live here anymore." R175 went into detail about the event over the weekend. The Progress note did no include any details of the situation.	F 166	that process. The facility has reviewed other grievances and identified no other current residents with outstanding unresolved grievances. By September 6th 2017 the facility will provide education on the grievance procedure to direct care staff members. The policy will also be reviewed with the resident council and resident community meetings of August 28th. Resident grievances will be audited by the Director of Program Services or designee and the results reported quarterly to the QAPI committee.	

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-5/25/17 Writer met with R175 to discuss the readmission of a resident on the same floor as her. R175 stated she was "really upset" and appalled the resident had been re-admitted and was living across the hall from her. She told the writer she was concerned he would become violent with her again and reviewed the incidents that occurred between her and the other resident on 5/21/17.

- 6/1/17 Writer received a phone call and stated to the person on the other end of the line, "As you know, I was attacked." Another resident threw a walker at my head, and he's still here.

- 6/2/17 Writer met with R175 to discuss her concerns regarding a resident who had an outburst last week in the television room that involved him throwing items (no contact made with persons from this) name calling, raised voice and general agitation.

A review of the progress notes did not include evidence of documentation of the incident reported to have happened on 6/21/17.

A review of a facility document titled Resident Suggestion/Complaint Form dated 5/31/17 identified a letter written by R175 to the facility administrator on 5/29/17. The letter indicated R175 felt "betrayed" by staff and felt no one cared about her safety. She indicated a resident had thrown a walker at her head and was upset that he returned to the facility and was placed in the room across the hall from her. R175 indicated, "I feel that I've not only been abused, but humiliated." In the letter, R175 also identified concerns regarding some grapefruit she had purchased and had been removed from her

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room. The attached Resident Suggestion/Complaint Form indicated R175 met with the executive director on May 30, 2017, and the complaint was referred to the facility grievance official. The complaint form indicated the grievance official met with R175 on May 31, 2017. The form indicated it was unfortunate that R175 was present for the worsening of the other residents symptoms. R175 was encouraged to seek staff assistance in the future if it appears a resident's symptoms may intrude on a peaceful environment.

During an interview on 8/2/17, at 10:26 a.m. the facility grievance official stated the facility had a grievance process for years but had recently "tightened it up." She stated the form the facility used was intended to prompt staff as to what to do and who needs to see it. She stated the grievance report is more of a suggestion of something she would like to happen or a complaint. The grievance official stated she met with R175 on June 12, 2017, regarding the incident with the other resident. She stated R175 stated it was distressing to her that he was residing across the hall from her. The grievance official stated she met with the interdisciplinary team and it was decided the other resident would move to a different floor. She stated she was not sure when this occurred. At 2:09 p.m. the grievance official stated she expected grievance to be dealt with immediately and the process should begin within 24 hours. She was not sure what the expected time frame for finishing a grievance and stated she would refer to the policy.

During an interview on 8/2/17, at 11:35 a.m. the director of program services stated when the

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incident occurred between R175 and the other resident, R75 stated the other resident called her a name and threw something at her. He stated initially he thought it was a resident to resident altercation but stated when he was called regarding the incident, the other resident was described as having thrown the walker down the hall.

During a subsequent interview on 8/2/17, at 1:52 p.m., R175 stated she did not feel the facility addressed her concerns about the other resident. She stated she felt they only addressed her concerns about the grapefruit. She stated when the other resident returned to the facility, it was a holiday weekend and a lot of staff were not in the facility and when he was admitted across the hall from her it caused her anxiety to "skyrocket." She stated she felt most concerns could be dealt with in a few weeks, but felt concerns regarding her safety should have been handled in a maximum of 2-3 days.

A facility policy titled Suggestions/Complaints (Grievance Procedure) dated 2/1/17 indicated If a resident of the facility has a concern or complaint about an issue affecting you, it is important to try to talk it over with the person involved in the situation. If talking things over does not resolve the problem, the next step is to take your concern to the program manager. At this point or at any other point in the process the resident has the right to put the concern in writing using the Resident Suggestion/Complaint Form. The grievance official is responsible for overseeing the timely and complete response to the residents complaints/grievances. The policy did not identify "timely" in regard to the completion of a grievance.

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F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adequate supervision to 1 of 3 residents (R100) reviewed for accidents who was deemed to have unsafe smoking behaviors. Findings include: R100's quarterly Minimum Data Set (MDS) dated 6/5/17 indicated he had intact cognition and was	F 323	Resident 100 was monitored and reassessed for safe smoking by three staff members independent of each other. It was noted that prior assessments had erroneously indicated he had always had burn holes. No burn holes have been noted. It was further identified that his pattern of smoking unfiltered, self rolled tobacco resulted in a pattern of ashing his cigarette by flicking the ash with his finger.	9/11/17

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F 323	Continued From page 8 independent with all activities of daily living. R100's care plan dated 8/1/17 identified impaired skin integrity and a potential for impaired skin integrity related to poor smoking practices. The care plan directed staff to apply Eucerin cream to both hands three times per week and instruct him to "ash" his cigarette into appropriate receptacle rather than touching the soldering ash with his fingers. The care plan further identified an inability to recognize unsafe smoking behavior and directed staff to encourage the use of adaptive smoking/lighting equipment. A review of a Safe Smoking Screening dated 10/13/16, indicated R100 had a history of unsafe smoking practices. The assessment indicated he sometimes kept his lighter on a safe setting, sometimes demonstrates ability to hold smoking materials safely, sometimes disposes of ashes appropriately, sometimes demonstrates and ability to extinguish smoking materials completely and always has burn marks on his clothing or person. The assessment indicated R100 needed interventions to smoke safely. A review of a Vulnerability Assessment and Abuse Prevention Plan dated 1/3/17 indicated R100 was unable to recognize unsafe smoking behavior. The Assessment indicated a safe smoking screening completed 10/13/16 indicated potentially unsafe smoking practices. The assessment identified R100 was observed using his fingers to dispose of cigarette ash by running his pointer and middle finger across the cigarette ash resulting significant callous and discoloration to fingers. At the time of the assessment there was no blistering or burning however, there is the potential due to him physically touching the ash. R100's clothing was observed to have burn	F 323	This did not cause a burn but had resulted in a callous and nicotine discoloration for which he was receiving regular hand soaks. VA and his family were consulted and agreed to the purchase of a rolling machine to self manufacture filtered cigarettes. VA independently made the purchase and has subsequently been self manufacturing filtered cigarettes. Subsequent observations indicate he routinely smokes while standing, safely ignites his smoking materials and appropriately handles the cigarette throughout the process of smoking. VA will continue to be monitored for safe smoking and continued use of filtered cigarettes. Any changes in his safe use of tobacco products will be addressed in his vulnerability plan. The facility has revised its safe smoking screening to facilitate a fuller assessment of how the residents uses tobacco products and steps in their use that may present a potential accident hazard beyond the inherent risk. By September 6th all residents known to use tobacco products will be reassessed and vulnerability plans will be developed to address identified concerns. Smoking screenings will be audited and compared to vulnerability plans by the Clinical Services Coordinator or designee and the results will be reported to the QAPI Committee.	

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marks from the ash falling on his clothing. He is advised to use filtered cigarettes and practice safe smoking techniques.

During an observation on 8/2/17, at 8:55 a.m. R100 was observed walking around the outdoor smoking area picking cigarette butts out of the ashtrays. R100 sat down and lit one of the butts. His fingers were stained a dark brown color.

During an observation on 8/2/17, at 1:02 p.m., R100 was observed smoking outside in front of the building. He was observed to put the cigarette out using his fingertips. R100 stated he had burned himself with cigarettes in the past and stated, "It don't hurt nothing, it's OK!"

During an interview on 8/2/17, at 11:21 a.m. mental health worker (MHW)-A stated when a resident is assessed to have unsafe smoking practices a vulnerability report is completed and the supervisor is notified. She stated staff should give them safe smoking techniques, watch them and limit smoking. She stated if they continue to have nicotine stains on hands or holes in clothing, it is a visible sign of poor practice they will watch them periodically. MHW-A stated she had not documented R100's smoking since last October but stated though his hands soaks it was noticeable he still had poor practices. She stated the facility suggested he used filtered cigarettes but he was not using them. She further stated staff "visualize" R100's clothing to look for any new burn holes.

During and interview on 8/2/17, at 12:36 p.m., Program Manager (PM)-A stated smoking assessments were completed annually. She stated during a smoking assessment R100 was

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F 323	Continued From page 10 deemed to have unsafe smoking practices. She stated education was provided to R100 regarding safe smoking and stated monitoring was done during weekly meetings. She stated staff performed visual assessments for potential burn holes in clothing and stated they try to replace clothing when it has holes. PM-A stated the facility does not do staff one to ones when residents are smoking and stated they might utilize and electronic lighter but had not offered that to R100. She further stated R100 was not following the recommendations for filtered cigarettes. During and interview on 8/2/17, at 1:15 p.m., the director of program services stated the smoking assessment completed on 10/13/16 would not have been the last time staff saw R100 smoke. He stated if R100 had sustained a burn they would look at more restrictive measures. A facility policy titled Smoking Policy and Procedure date 7/19/17, indicated at the time of admission and quarterly thereafter residents are assessed as to his/her ability to engage in safe smoking behaviors. Residents who are assessed to be vulnerable in the area of smoking will have a vulnerability plan outlined in the Vulnerability Assessment and Abuse Prevention Plan.	F 323		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug	F 329		9/11/17

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F 329	Continued From page 11 therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 resident (R25) pulse was checked for efficacy of the medication, prior to administering Digoxin (medication used to slow the heart rate in patients with atrial fibrillation) and failed to ensure monitoring of orthostatic	F 329	It is the desire of Andrew Residence facility staff to provide the best practicable care to every resident. The facility has a policy and procedure to outline best practices of medication administration and related treatment and/or monitoring.	

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F 329	Continued From page 12 hypotension for 1 of 1 resident (R2) reviewed for unnecessary medications. Findings include: R25's care plan dated 4/5/17, indicated resident had tachycardia due to paroxysmal atrial fibrillation with rapid ventricular response. The care plan directed staff to Administer medications per medical doctor (MD) order. Hold Digoxin per MD guidelines. Monitor pulse daily on medication administration record (MAR). Apical heart rate to be obtained daily and Digoxin to be held if heart rate is less than 60 beats per minute. R25's Physician Orders dated 6/1/17, indicated resident had orders for Digoxin 0.25 milligram (mg) 1 tablet orally daily and directed staff to "HOLD IF APICAL PULSE < [less than] 60." R25's diagnoses included atrial fibrillation and orthostatic hypotension obtained from the annual Minimum Data Set (MDS) dated 6/28/17. A review of the May 2017, June 2017, and July 2017 Medication Administration Record (MAR) and Treatment administration record (TAR) sheets revealed the heart rate had not been documented for three days, nine days and 11 days respectively. The medication was signed off as given. On 8/1/17, at 2:20 p.m. the consultant pharmacist reviewed the June and July 2017 MAR's and TAR's verified the missing documentation of the apical pulses with medications as directed by the physician order. She stated the staff was supposed to do it as resident was fragile.	F 329	Corrective action was taken following completion of survey to ensure that the identified resident (R25) has experienced no ill effect as a result of the lack of monitoring of her pulse in conjunction with the administration of the prescribed medication digoxin. Additional interventions were put in place to ensure the nurse on duty on the day shift (when the digoxin is administered) has an additional alert incorporated into the nursing report template to ensure that apical pulse monitoring is completed as ordered. The interdisciplinary team on the 5th floor where R25 resides was provided with additional guidance and clarification on the intent and rationale of the pulse monitoring with the digoxin. Corrective action was taken following completion of survey to ensure that the identified resident (R2) has experienced no ill effect as a result of the lack of monitoring of his blood pressure and to ensure that monitoring is completed as ordered. The interdisciplinary team on the 5th floor where R2 resides was provided with additional guidance and clarification on the intent and rationale of the blood pressure monitoring. An audit was conducted of all resident medication administration records for the month of July 2017 to review documentation of vital sign monitoring related to prescribed medications or condition. Facility plans for modification to resident vital sign monitoring will be	

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	24E116	A. BUILDING _____ B. WING _____	08/02/2017

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

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F 329	Continued From page 13 On 8/2/17, at 11:04 a.m. registered nurse (RN)-A reviewed the MAR and TAR sheets for July 2017, and verified there was no documentation of a heart rate prior to administration of Digoxin as directed by the physician order. RN-A stated the staff was supposed to check the pulse before the medication was given and thought was an omission, stating "the MAR speaks for itself." On 8/2/17, at 12:37 p.m. the director of nursing (DON) stated she would expect the staff to check the pulse and record it prior to giving the medication. The DON stated the night shift staff was responsible for auditing the MAR to check for omissions. She stated it was communicated to the staff to make sure all the omissions were resolved before the sheets are uploaded to the electronic medical record. The DON further stated the nurse was supposed to do the apical pulse and not the trained medication aide (TMA) and thought the TMA was probably giving medications on those days with missing documentation. R2's quarterly Minimum data set (MDS) dated 4/30/17, indicated he was severely cognitively impaired. R2's care plan dated 5/8/17, identified a risk for orthostatic hypotension related to frequent dizziness and heart concerns. A review of R2's Physician's Orders identified the use of Amlodipine (used to treat high blood pressure) and Lisinopril/ Hydrochlorothiazide (used to treat high blood pressure). Side effects of both medications include dizziness and light headedness. A review of R2's Physician's Orders indicated Check orthostatic blood pressure (BP) weekly and contact physician if BP greater than 130/80	F 329	completed on or before September 11, 2017. These modifications include, but are not limited to: changes in frequency or time of day of monitoring to better ensure completion in accordance with clinical standards, and changes in formatting correlation of the vital sign monitoring to the medication order. Current nightly auditing of all MARs will be modified to include a specific focus on assurance that vital sign monitoring took place. Any omissions of vital sign monitoring will additionally be routed to the Director of Nursing Services or designee to oversee the process of completion or correction. Status and progress will be presented at monthly medication administration meetings and Quality Assurance Performance Improvement meetings.	

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F 329	Continued From page 14 two times in a row. A review of facility treatment Records dated May 2017 - July 2017 identified the following: - 5/2/17 scheduled orthostatic BP not taken. - 5/9/17 siting and standing blood pressure taken. - 5/1617 scheduled orthostatic BP not taken. - 5/30/17 Sitting BP taken, no standing BP taken. - 6/6/17 BP taken siting and standing. - 6/13/17, 6/20/17 and 6/27/17 No scheduled BP taken. - 7/4/17 and 7/11/17 no scheduled orthostatic BP taken. - 7/18/17 orthostatic BP taken sitting and standing. - 7/25/17 no orthostatic BP taken. During an interview on 8/2/17, at 12:30 p.m., the director of nursing (DON) stated the orthostatic BP's should be checked during the medication pass. She stated the over night shift completes a nightly audit to look for omissions in the medication and treatment administration records. The DON stated she would also be looking at the pharmacy consultant reviews for omissions. She stated she was not aware R2's orthostatic BP's were not being completed as directed by the physician.	F 329		

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F 329	Continued From page 15 The facility Medication Administration Record policy dated 4/1/08, directed staff to ensure all medication record forms for each resident were completed and reviewed to ensure all the prescribed medications and treatments were entered correctly so as to facilitate the appropriate and proper administration and required documentation.	F 329		

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

AMENDED LETTER REPLACING NH SURVEY LICENSING LETTER DATED AUGEST 16, 2017

Electronically delivered
August 21, 2017

Mrs. Karen Foy, Administrator
Andrew Residence
1215 South 9th Street
Minneapolis, MN 55404

Re: Enclosed State Boarding Care Home Licensing Orders - Project Number SE116026

Amended letter replacing NH Survey Licensing Letter dated August 16, 2017.

Dear Mrs. Foy:

The above facility survey was completed on August 2, 2017 for the purpose of assessing compliance with Minnesota Department of Health Boarding Care Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA

STATE STATUTES/RULES.

When all orders are corrected, the order form should be acknowledged electronically and submitted to this office at 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 me.

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

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

Feel free to contact me with any questions related to this letter.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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3 000	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are	3 000		

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3 000	Continued From page 1 delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On July 31, August 1 & 2, 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 Board and Care 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	3 000		

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3 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	3 000		
3 945	MN Rule 4655.6400 Subp. 1 Adequate Care; Care in General Subpart 1. Care in general. Each patient or resident shall receive nursing care or personal and custodial care and supervision based on individual needs. Patients and residents shall be encouraged to be active, to develop techniques for self-help, and to develop hobbies and interests. Nursing home patients shall be up and out of bed as much as possible unless the attending physician states in writing on the patient ' s medical record that the patient must remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adequate supervision to 1 of 3 residents (R100) reviewed for accidents who was deemed to have unsafe smoking behaviors. Findings include: R100's quarterly Minimum Data Set (MDS) dated 6/5/17 indicated he had intact cognition and was independent with all activities of daily living. R100's care plan dated 8/1/17 identified impaired skin integrity and a potential for impaired skin	3 945	Corrected	9/6/17

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3 945	Continued From page 3	3 945		

integrity related to poor smoking practices. The care plan directed staff to apply Eucerin cream to both hands three times per week and instruct him to "ash" his cigarette into appropriate receptacle rather than touching the soldering ash with his fingers. The care plan further identified an inability to recognize unsafe smoking behavior and directed staff to encourage the use of adaptive smoking/lighting equipment.

A review of a Safe Smoking Screening dated 10/13/16, indicated R100 had a history of unsafe smoking practices. The assessment indicated he sometimes kept his lighter on a safe setting, sometimes demonstrates ability to hold smoking materials safely, sometimes disposes of ashes appropriately, sometimes demonstrates and ability to extinguish smoking materials completely and always has burn marks on his clothing or person. The assessment indicated R100 needed interventions to smoke safely.

A review of a Vulnerability Assessment and Abuse Prevention Plan dated 1/3/17 indicated R100 was unable to recognize unsafe smoking behavior. The Assessment indicated a safe smoking screening completed 10/13/16 indicated potentially unsafe smoking practices. The assessment identified R100 was observed using his fingers to dispose of cigarette ash by running his pointer and middle finger across the cigarette ash resulting significant callous and discoloration to fingers. At the time of the assessment there was no blistering or burning however, there is the potential due to him physically touching the ash. R100's clothing was observed to have burn marks from the ash falling on his clothing. He is advised to use filtered cigarettes and practice safe smoking techniques.

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3 945	Continued From page 4 During an observation on 8/2/17, at 8:55 a.m. R100 was observed walking around the outdoor smoking area picking cigarette butts out of the ashtrays. R100 sat down and lit one of the butts. His fingers were stained a dark brown color. During an observation on 8/2/17, at 1:02 p.m., R100 was observed smoking outside in front of the building. He was observed to put the cigarette out using his fingertips. R100 stated he had burned himself with cigarettes in the past and stated, "It don't hurt nothing, it's OK!" During an interview on 8/2/17, at 11:21 a.m. mental health worker (MHW)-A stated when a resident is assessed to have unsafe smoking practices a vulnerability report is completed and the supervisor is notified. She stated staff should give them safe smoking techniques, watch them and limit smoking. She stated if they continue to have nicotine stains on hands or holes in clothing, it is a visible sign of poor practice they will watch them periodically. MHW-A stated she had not documented R100's smoking since last October but stated though his hands soaks it was noticeable he still had poor practices. She stated the facility suggested he used filtered cigarettes but he was not using them. She further stated staff "visualize" R100's clothing to look for any new burn holes. During and interview on 8/2/17, at 12:36 p.m., Program Manager (PM)-A stated smoking assessments were completed annually. She stated during a smoking assessment R100 was deemed to have unsafe smoking practices. She stated education was provided to R100 regarding safe smoking and stated monitoring was done during weekly meetings. She stated staff performed visual assessments for potential burn	3 945		

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3 945	Continued From page 5 holes in clothing and stated they try to replace clothing when it has holes. PM-A stated the facility does not do staff one to ones when residents are smoking and stated they might utilize and electronic lighter but had not offered that to R100. She further stated R100 was not following the recommendations for filtered cigarettes. During and interview on 8/2/17, at 1:15 p.m., the director of program services stated the smoking assessment completed on 10/13/16 would not have been the last time staff saw R100 smoke. He stated if R100 had sustained a burn they would look at more restrictive measures. A facility policy titled Smoking Policy and Procedure date 7/19/17, indicated at the time of admission and quarterly thereafter residents are assessed as to his/her ability to engage in safe smoking behaviors. Residents who are assessed to be vulnerable in the area of smoking will have a vulnerability plan outlined in the Vulnerability Assessment and Abuse Prevention Plan. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	3 945		
31105	MN Rule 4655.7810 Distribution of Medications A system shall be developed in each boarding care home to assure that all medications are distributed safely and properly. All medications shall be distributed and taken exactly as ordered by the physician. Any medication errors or resident reactions shall be reported to the physician at once and an explanation made in the resident's personal care record.	31105		9/6/17

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31105	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 resident (R25) pulse was checked for efficacy of the medication, prior to administering Digoxin (medication used to slow the heart rate in patients with atrial fibrillation) and failed to ensure monitoring of orthostatic hypotension for 1 of 1 resident (R2) reviewed for unnecessary medications. Findings include: R25's care plan dated 4/5/17, indicated resident had tachycardia due to paroxysmal atrial fibrillation with rapid ventricular response. The care plan directed staff to Administer medications per medical doctor (MD) order. Hold Digoxin per MD guidelines. Monitor pulse daily on medication administration record (MAR). Apical heart rate to be obtained daily and Digoxin to be held if heart rate is less than 60 beats per minute. R25's Physician Orders dated 6/1/17, indicated resident had orders for Digoxin 0.25 milligram (mg) 1 tablet orally daily and directed staff to "HOLD IF APICAL PULSE < [less than] 60." R25's diagnoses included atrial fibrillation and orthostatic hypotension obtained from the annual Minimum Data Set (MDS) dated 6/28/17. A review of the May 2017, June 2017, and July 2017 Medication Administration Record (MAR) and Treatment administration record (TAR) sheets revealed the heart rate had not been documented for three days, nine days and 11 days respectively. The medication was signed off as given.	31105	corrected	

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31105	Continued From page 7 On 8/1/17, at 2:20 p.m. the consultant pharmacist reviewed the June and July 2017 MAR's and TAR's verified the missing documentation of the apical pulses with medications as directed by the physician order. She stated the staff was supposed to do it as resident was fragile. On 8/2/17, at 11:04 a.m. registered nurse (RN)-A reviewed the MAR and TAR sheets for July 2017, and verified there was no documentation of a heart rate prior to administration of Digoxin as directed by the physician order. RN-A stated the staff was supposed to check the pulse before the medication was given and thought was an omission, stating "the MAR speaks for itself." On 8/2/17, at 12:37 p.m. the director of nursing (DON) stated she would expect the staff to check the pulse and record it prior to giving the medication. The DON stated the night shift staff was responsible for auditing the MAR to check for omissions. She stated it was communicated to the staff to make sure all the omissions were resolved before the sheets are uploaded to the electronic medical record. The DON further stated the nurse was supposed to do the apical pulse and not the trained medication aide (TMA) and thought the TMA was probably giving medications on those days with missing documentation. R2's quarterly Minimum data set (MDS) dated 4/30/17, indicated he was severely cognitively impaired. R2's care plan dated 5/8/17, identified a risk for orthostatic hypotension related to frequent dizziness and heart concerns. A review of R2's Physician's Orders identified the use of Amlodipine (used to treat high blood pressure) and Lisinopril/ Hydrochlorothiazide	31105		

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ANDREW RESIDENCE	1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404

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31105	Continued From page 8 (used to treat high blood pressure). Side effects of both medications include dizziness and light headedness. A review of R2's Physician's Orders indicated Check orthostatic blood pressure (BP) weekly and contact physician if BP greater than 130/80 two times in a row. A review of facility treatment Records dated May 2017 - July 2017 identified the following: - 5/2/17 scheduled orthostatic BP not taken. - 5/9/17 siting and standing blood pressure taken. - 5/1617 scheduled orthostatic BP not taken. - 5/30/17 Sitting BP taken, no standing BP taken. - 6/6/17 BP taken siting and standing. - 6/13/17, 6/20/17 and 6/27/17 No scheduled BP taken. - 7/4/17 and 7/11/17 no scheduled orthostatic BP taken. - 7/18/17 orthostatic BP taken sitting and standing. - 7/25/17 no orthostatic BP taken. During an interview on 8/2/17, at 12:30 p.m., the director of nursing (DON) stated the orthostatic BP's should be checked during the medication pass. She stated the over night shift completes a nightly audit to look for omissions in the medication and treatment administration records.	31105		

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	00993	A. BUILDING: _____ B. WING _____	08/02/2017

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

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31105	Continued From page 9 The DON stated she would also be looking at the pharmacy consultant reviews for omissions. She stated she was not aware R2's orthostatic BP's were not being completed as directed by the physician. The facility Medication Administration Record policy dated 4/1/08, directed staff to ensure all medication record forms for each resident were completed and reviewed to ensure all the prescribed medications and treatments were entered correctly so as to facilitate the appropriate and proper administration and required documentation. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	31105		
31880	MN Rule 144.651 Subd. 20 Patients & Residents of HCF Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every	31880		9/6/17

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31880	Continued From page 10 residential program as defined in section 253C.01, every non-acute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the resolution of grievances in a timely manner for 1 of 1 resident (R175) reviewed who had filed a grievance with the facility. Findings include: R175's Quarterly Minimum Data Set (MDS) indicated she had intact cognition. R175's care plan dated 3/27/17 identified psychiatric symptoms that impair judgement and functioning. During an interview on 8/1/17, at 3:34 p.m. R175 approached survey team and identified the	31880	Corrected	

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31880	Continued From page 11	31880		

following concern: R175 stated on or around Memorial Day weekend of 2017 another resident in the facility threw a walker at her and ripped a bulletin board off the wall. She stated the other resident was removed from the facility but then returned a few days later. R175 stated upon his return he was placed in a room right across the hall from her and stated it made her anxious. She stated she felt like she was the one being punished. R175 further stated she was not aware of a grievance process but talked to staff when she had concerns.

A review of a facility Interdisciplinary Progress Notes identified the following:

- 5/19/17 Writer met with R175 to discuss the people who live on the same floor as she does. "These people cause her to feel unsafe when she is in her room."

- 5/23/17 Writer met with R175 to discuss her request for a discharge. R175 explained to writer she had been involved in a situation over the weekend that "scared her to the point where she does not want to live here anymore." R175 went into detail about the event over the weekend. The Progress note did no include any details of the situation.

-5/25/17 Writer met with R175 to discuss the readmission of a resident on the same floor as her. R175 stated she was "really upset" and appalled the resident had been re-admitted and was living across the hall from her. She told the writer she was concerned he would become violent with her again and reviewed the incidents that occurred between her and the other resident on 5/21/17.

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31880	Continued From page 12 - 6/1/17 Writer received a phone call and stated to the person on the other end of the line, "As you know, I was attacked." Another resident threw a walker at my head, and he's still here. - 6/2/17 Writer met with R175 to discuss her concerns regarding a resident who had an outburst last week in the television room that involved him throwing items (no contact made with persons from this) name calling, raised voice and general agitation. A review of the progress notes did not include evidence of documentation of the incident reported to have happened on 6/21/17. A review of a facility document titled Resident Suggestion/Complaint Form dated 5/31/17 identified a letter written by R175 to the facility administrator on 5/29/17. The letter indicated R175 felt "betrayed" by staff and felt no one cared about her safety. She indicated a resident had thrown a walker at her head and was upset that he returned to the facility and was placed in the room across the hall from her. R175 indicated, "I feel that I've not only been abused, but humiliated." In the letter, R175 also identified concerns regarding some grapefruit she had purchased and had been removed from her room. The attached Resident Suggestion/Complaint Form indicated R175 met with the executive director on May 30, 2017, and the complaint was referred to the facility grievance official. The complaint form indicated the grievance official met with R175 on May 31, 2017. The form indicated it was unfortunate that R175 was present for the worsening of the other residents symptoms. R175 was encouraged to seek staff assistance in the future if it appears a resident's symptoms may intrude on a peaceful	31880		

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31880	Continued From page 13 environment. During an interview on 8/2/17, at 10:26 a.m. the facility grievance official stated the facility had a grievance process for years but had recently "tightened it up." She stated the form the facility used was intended to prompt staff as to what to do and who needs to see it. She stated the grievance report is more of a suggestion of something she would like to happen or a complaint. The grievance official stated she met with R175 on June 12, 2017, regarding the incident with the other resident. She stated R175 stated it was distressing to her that he was residing across the hall from her. The grievance official stated she met with the interdisciplinary team and it was decided the other resident would move to a different floor. She stated she was not sure when this occurred. At 2:09 p.m. the grievance official stated she expected grievance to be dealt with immediately and the process should begin within 24 hours. She was not sure what the expected time frame for finishing a grievance and stated she would refer to the policy. During an interview on 8/2/17, at 11:35 a.m. the director of program services stated when the incident occurred between R175 and the other resident, R75 stated the other resident called her a name and threw something at her. He stated initially he thought it was a resident to resident altercation but stated when he was called regarding the incident, the other resident was described as having thrown the walker down the hall. During a subsequent interview on 8/2/17, at 1:52 p.m., R175 stated she did not feel the facility addressed her concerns about the other resident.	31880		

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31880	Continued From page 14 She stated she felt they only addressed her concerns about the grapefruit. She stated when the other resident returned to the facility, it was a holiday weekend and a lot of staff were not in the facility and when he was admitted across the hall from her it caused her anxiety to "skyrocket." She stated she felt most concerns could be dealt with in a few weeks, but felt concerns regarding her safety should have been handled in a maximum of 2-3 days. A facility policy titled Suggestions/Complaints (Grievance Procedure) dated 2/1/17 indicated If a resident of the facility has a concern or complaint about an issue affecting you, it is important to try to talk it over with the person involved in the situation. If talking things over does not resolve the problem, the next step is to take your concern to the program manager. At this point or at any other point in the process the resident has the right to put the concern in writing using the Resident Suggestion/Complaint Form. The grievance official is responsible for overseeing the timely and complete response to the residents complaints/grievances. The policy did not identify "timely" in regard to the completion of a grievance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	31880		

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	24E116	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/02/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED As VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Health Care Safety Code, NFPA 99. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/28/2017

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

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K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Andrew Residence is a 5-story building with a basement. The building was constructed in 1973, with an addition in 1978 and was determined to be of Type II(222) construction. Each floor of the facility is divided into 2 smoke zones by 30 minute fire barriers. 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 corridor smoke detection, resident room detectors and in common areas that are on the fire alarm system. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have either heat detection or smoke detection that are on the fire alarm system.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 212 beds and had a census of 208 at the time of the survey. The facility was surveyed as one building. At this time, the conditions of 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could create the misinterpretation of the water supply and allow for	K 353	The gauge was replaced on 08/08/2017; it is properly labeled and dated. Steve Morice, Fire and Safety Director will be responsible for monitoring this correction. He has been in contact with our contracted service provider to ensure	9/11/17

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K 353	Continued From page 3 the spread of fire. This could affect all of the 208 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour at 2:35 pm on 08/02/2017 observations revealed the gauge on the sprinkler riser was past due for calibration or replacement. It was marked last inspected on 02/2012. This deficient condition was confirmed by the facility Maintenance Director.	K 353	maintenance will be done and documented in a timely manner.	
K 371 SS=F	NFPA 101 Subdivision of Building Spaces - Smoke Compar Subdivision of Building Spaces - Smoke Compartments 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 Detail in REMARKS zone dimensions including length of zones and dead-end corridors. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain smoke barriers for the purpose of subdivision of building spaces in accordance with NFPA 101, 2012 edition, sections 19.3.7 & 8.5. This deficient practice could allow for smoke to transfer from one compartment to another making evacuation more difficult. This condition could affect 16 of the 45 residents and an undetermined amount of staff	K 371	Gypsum board will be properly installed (where missing) to the roof deck on floors 2 through five. This will be completed by September 11, 2017. Tim Ryden, Director of Support Services will be responsible to ensure installation	9/11/17

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K 371	Continued From page 4 and visitors. Findings include: On the facility tour on 08/02/2017 observations revealed the smoke barriers on floors 2 through five did not have properly constructed smoke barriers. Approximately 1/4 of the wall on one side of the barrier above the ceiling did not have gypsum to the roof deck. This deficient condition was confirmed by the facility Maintenance Director.	K 371	and ongoing monitoring.	
K 920 SS=D	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.	K 920		9/6/17

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K 920	Continued From page 5 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure multiple outlet adapters are in accordance with the 2012 edition of NFPA 99 section 10.2..4.2.1 and the use of power strips comply with 10.2.3.6. This deficient practice could affect and an undetermined amount of patients, staff and visitors. Findings include: On the facility tour at 12:28 and 12:40 pm on 08/02/2017 observations revealed daisy chained power taps in use in resident rooms 406 and 427. This deficient condition was confirmed by the facility Maintenance Director.	K 920	The improper use of power taps in rooms 406 and 427 was corrected immediately on the date of the survey. An assessment of power tap usage by residents will be completed by August 23, 2017. Steve Morice, Fire and Safety Director will monitor this on an ongoing basis.	