

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: FEIF
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: <u>7</u> (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 05/15/2015 (L34) 8. ACCREDITATION STATUS: <u> </u> (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	7. PROVIDER/SUPPLIER CATEGORY <u>10</u> (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) <p style="text-align: center;">12/31</p>															
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: <u> </u> 1. Acceptable POC X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A (L12) And/Or Approved Waivers Of The Following Requirements: <u> </u> 2. Technical Personnel <u> </u> 6. Scope of Services Limit <u> </u> 3. 24 Hour RN <u> </u> 7. Medical Director <u> </u> 4. 7-Day RN (Rural SNF) <u> </u> 8. Patient Room Size <u> </u> 5. Life Safety Code <u> </u> 9. Beds/Room																
14. LTC CERTIFIED BED BREAKDOWN <table style="width:100%; border: none;"> <tr> <td style="width:15%;">18 SNF</td> <td style="width:15%;">18/19 SNF</td> <td style="width:15%;">19 SNF</td> <td style="width:15%;">ICF</td> <td style="width:15%;">IID</td> </tr> <tr> <td></td> <td></td> <td style="text-align: center;">212</td> <td></td> <td></td> </tr> <tr> <td>(L37)</td> <td>(L38)</td> <td>(L39)</td> <td>(L42)</td> <td>(L43)</td> </tr> </table>	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)	
18 SNF	18/19 SNF	19 SNF	ICF	IID													
		212															
(L37)	(L38)	(L39)	(L42)	(L43)													
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):																	
17. SURVEYOR SIGNATURE <u>Gloria Derfus, Unit Supervisor</u>	Date : 05/19/2015 (L19)	18. STATE SURVEY AGENCY APPROVAL <u>Kamala Fiske-Downing, Enforcement Specialist</u> 07/14/2015 (L20)															

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

19. DETERMINATION OF ELIGIBILITY <u> </u> 1. Facility is Eligible to Participate <u> </u> 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)	
28. TERMINATION DATE: (L28)	29. INTERMEDIARY/CARRIER NO. (L31)	26. TERMINATION ACTION: (L30) VOLUNTARY <u>00</u> 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
31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION OF APPROVAL DATE (L33)	30. REMARKS Posted 05/20/2015 Co. DETERMINATION APPROVAL



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24E116

July 14, 2015

Mrs. Karen Foy, Administrator
Andrew Residence
1215 South 9th Street
Minneapolis, Minnesota 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 May 6, 2015 the above facility is certified for:

212 Skilled Nursing Facility Beds

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

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

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

Please contact me if you have any questions

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive style.

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 19, 2015

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

RE: Project Number SE116024

Dear Mrs. Foy:

On April 30, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 24, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On May 15, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 24, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 6, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 24, 2015, effective May 6, 2015 and therefore remedies outlined in our letter to you dated April 30, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads "Kamala Fiske-Downing".

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 24E116	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 5/15/2015
Name of Facility ANDREW RESIDENCE	Street Address, City, State, Zip Code 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404	

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0334	Correction Completed 05/06/2015	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # 483.25(n)		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	

Reviewed By _____	Reviewed By GD/kfd	Date: 05/19/2015	Signature of Surveyor: 18623	Date: 05/15/2015
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 4/24/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: April 30, 2015

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

RE: Project Number SE116024

Dear Mrs. Foy:

On April 24, 2015, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 3, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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

- 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 July 24, 2015 (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 October 24, 2015 (six months after the

Andrew Residence

April 30, 2015

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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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm>

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Please contact me if you have any questions about this electronic notice.

Andrew Residence
April 30, 2015
Page 6

Sincerely,

A handwritten signature in cursive script that reads "Anne Kleppe".

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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

PRINTED: 05/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24E116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2015
NAME OF PROVIDER OR SUPPLIER ANDREW RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza	F 334		5/6/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/11/2015

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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F 334	<p>Continued From page 1 immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p>	F 334			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24E116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2015
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F 334	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R189) was offered and/or received pneumococcal vaccinations as recommended by Centers for Disease Control (CDC). Findings include: The facility provided information about R189 refusing the pneumococcal vaccination on 10/3/12, per the Regions Hospital Behavioral Health Nursing Initial assessment dated 10/3/12. The quarterly Minimum Data Set (MDS) dated 12/8/14, indicated R189 was admitted to the facility on 1/12/14. After R189 was re-admitted back to facility on 12/8/14, the immunization record lacked documentation if R189 had been informed about the benefits and risks of immunizations. The medical record lacked evidence a pneumococcal vaccination had been ordered by the physician, if R189 received the vaccination, or if it was contraindicated or refused by R189. On 4/23/15, at 1:04 p.m. when interviewed, director of nursing (DON) stated we should have asked for an order from the primary physician. Andrew Resident Influenza and Pneumococcal Vaccine Program for Residents policy dated 2/5/08, indicated "Pneumococcal Vaccine 1.	F 334	It is the desire of Andrew Residence facility staff to provide the best practicable care to every resident. The facility has developed a comprehensive Infection Control program, which includes a policy and procedure to address influenza and pneumococcal vaccination of residents. Corrective action was taken following completion of survey to ensure that the identified resident (R189) was provided information and offered the pneumococcal vaccination. The resident subsequently consented to receiving the vaccination at her annual physical exam with her primary medical clinic, scheduled for 6/26/15. An audit was conducted of all resident charts for documentation of pneumococcal vaccine and evaluation of indication for repeat vaccination dependent on age and previous vaccination. Any residents identified for whom a pneumococcal vaccination is outstanding, requirements will be met by June 3, 2015, per facility policy of seeking resident/representative consent and physician order to administer in the facility or during a clinic visit. Current monthly auditing of routine appointment due dates will be modified to include pneumococcal vaccination status.		

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

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NAME OF PROVIDER OR SUPPLIER ANDREW RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404		
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F 334	Continued From page 3 Andrew nurses ascertain each resident's pneumococcal vaccination status. If the resident is not currently immunized or if vaccination history is unknown, a vaccine order is requested from the primary physician. If the physician authorizes vaccination, the resident will receive it at the medical clinic."	F 334	These reports are distributed to floors on a monthly basis. Additionally, vaccination status will be transferred into the resident's electronic health record by 5/31/15, to ensure systematic reporting mechanisms. The Director of Nursing, or designee, will oversee the status of these audits and pneumococcal vaccination status. Status and progress will be presented at quarterly Infection Control committee meetings and Quality Assurance meetings. Nursing staff will receive education on the pneumococcal vaccine and current CDC immunization guidelines, as well as the facility policy and procedure during the May 7th, 2015 bi-weekly nurses meeting. All nursing staff will complete an acknowledgement of policy and procedure review and understanding by 5/31/15.		

FE116023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24E116	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2015
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K 000	<p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Andrew Residence was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.</p> <p>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 a smoke barrier.</p> <p>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 (1999 edition). The facility has a fire alarm system with corridor smoke detection and in common areas that are on the fire alarm system. The fire alarm system is monitored for automatic fire department notification.</p> <p>The facility has a capacity of 212 beds and had a census of 211 at the time of the survey.</p> <p>The requirement at 42 CFR, Subpart 483.70(a) is MET.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: April 30, 2015

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

Re: Enclosed State Boarding Care Home Licensing Orders - Project Number SE116024

Dear Mrs. Foy:

The above facility survey was completed on April 24, 2015 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 surveyors 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.

Andrew Residence

April 30, 2015

Page 2

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:

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

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

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

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

Please contact me if you have any questions about this electronic notice.

Sincerely,



Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00993	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2015
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NAME OF PROVIDER OR SUPPLIER ANDREW RESIDENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404
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3 000	<p>INITIAL COMMENTS</p> <p>*****ATTENTION*****</p> <p>BOARDING CARE HOME LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On April, 21, 22, and 23, 2015, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health,</p>	3 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 05/11/15
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Minnesota Department of Health

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3 000	<p>Continued From page 1</p> <p>Health Regulation Division, Licensing and Certification Program; PO Box 64900, Saint Paul, MN 55164-0900</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.</p> <p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.</p>	3 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.</p>	
3 601	<p>MN St. Statute 144.56 Subp. 2c Tuberculosis Prevention And Control</p> <p>(a) A boarding care home must establish and maintain a comprehensive tuberculosis infection</p>	3 601		5/20/15

Minnesota Department of Health

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3 601	<p>Continued From page 2</p> <p>control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of The guidelines.</p> <p>(b) Written compliance with this subdivision must be maintained by the boarding care home.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure symptom screening was completed for 5 of 5 residents (R223, R186, R221, R220, R219); a medical evaluation for tuberculosis (TB) a contagious and an often severe airborne disease caused by a bacterial infection, screening was completed for 1 of 5 residents (R223) with positive tuberculin skin test; the facility failed to ensure test results were recorded for 2 of 5 residents (R220, R219); 1 of 5 employees (E3) received a second two-step test (TST). In addition, the policy did not include TB symptom assessment for residents upon admission.</p>	3 601	<p>Nursing staff have been educated regarding CDC recommendations and appropriate documentation. Facility polices have been updated to reflect CDC recommendations. Systems have been implemented to audit and monitor going forward. The Director of Nursing or designee will monitor implementaton and report to the Quality Assurance Committee.</p>	

Minnesota Department of Health

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3 601	<p>Continued From page 3</p> <p>Findings include:</p> <p>Screening: R223 was admitted to the facility on 3/27/15, per the Admission Record and the Baseline TB Screening Tool for Healthcare Workers (HCWs) had not been completed.</p> <p>R186 was admitted to the facility on 11/4/14, per the Admission Record and the Baseline TB Screening Tool for HCWs had not been completed.</p> <p>R221 was admitted to the facility on 1/6/15, per the Admission Record and the Baseline TB Screening Tool for HCWs had not been completed.</p> <p>R220 was admitted to the facility on 12/29/14, per the Admission Record and the Baseline TB Screening Tool for HCWs had not been completed.</p> <p>R219 was admitted to the facility on 12/16/14, per the Admission Record and the Baseline TB Screening Tool for HCWs had not been completed.</p> <p>Evaluation: R223 was admitted to the facility on 3/27/15, per the Admission Record and R223's immunization record revealed R223 had chest x-ray (CXR) prior to coming into the facility and a history of positive Mantoux. The medical record lacked a medical evaluation to rule out infectious disease.</p> <p>Test results: R220 was admitted to the facility on 12/29/14, per the Admission Record and R220's TST - first step</p>	3 601		

Minnesota Department of Health

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3 601	<p>Continued From page 4</p> <p>and TST - second step did not have negative reading results.</p> <p>R219 was admitted to the facility on 12/16/14, per the Admission Record and R219 TST - first step and TST - second step did not have negative reading results.</p> <p>Employee Testing: Review of employee 3 (E3) Baseline TB Screening Tool for HCWs indicated hire date of 1/26/14. It also indicated E3 TST - first step was given on 11/21/14, and was read on 11/23/14, with results of 0.0 millimeters (mm), negative. It did not indicate a TST - second step was given. The director of nursing (DON) confirmed she did not get TST - second step and was no longer employed. The employee worked in the facility until March of 2015.</p> <p>On 4/23/15, at 1:13 p.m. DON stated they do not do resident symptom screening for TB that was a pending policy. Only issued for employees, requested policy in place for residents, it was not provided. However, the policy did not include symptom screening for residents upon admission. That was verified by DON.</p> <p>Andrew Resident Tuberculosis Infection Control Program dated 5/16/14, pending indicated "2. Tuberculosis Screening of Residents a. For all new residents, a TST will be done within 72 hours of admission if there is no documented TST result from within 3 months prior to admission. B. The 2-step TST method will be performed per procedure. 1. The first step must be performed within 72 hours of admission. 2. If the first step is negative, the second test will be administered one to three weeks later in addition to a symptom screening. C. Residents with a documented</p>	3 601		

Minnesota Department of Health

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3 601	<p>Continued From page 5</p> <p>history of a previous positive TST will not be retested. e. TST results will be documented in the resident ' s medical record. 1. Skin test results will be documented in millimeters of induration rather that stating results as " positive" or "negative." a. History of Positive TST or IGRA [Interferon-Gamma Release Assays] 1. A baseline CXR will be done within 72 hours of admission unless a CXR was done within the previous 3 months and results are available." SUGGESTED METHOD FOR CORRECTION: The director of nursing could educate nursing staff on appropriate documentation of results of TST per Centers for Disease Control and Prevention (CDC) recommendations. The director of nursing and/or designee could assure facility policies are current, implemented and monitored and provide direction on how to properly perform, read and document results of a TST.</p> <p>TIME PERIOD FOR CORRECTION: Twenty One (21) days.</p>	3 601		

Minnesota Department of Health

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3 601	<p>Continued From page 5</p> <p>history of a previous positive TST will not be retested. e. TST results will be documented in the resident ' s medical record. 1. Skin test results will be documented in millimeters of induration rather that stating results as " positive" or "negative." a. History of Positive TST or IGRA [Interferon-Gamma Release Assays] 1. A baseline CXR will be done within 72 hours of admission unless a CXR was done within the previous 3 months and results are available." SUGGESTED METHOD FOR CORRECTION: The director of nursing could educate nursing staff on appropriate documentation of results of TST per Centers for Disease Control and Prevention (CDC) recommendations. The director of nursing and/or designee could assure facility policies are current, implemented and monitored and provide direction on how to properly perform, read and document results of a TST.</p> <p>TIME PERIOD FOR CORRECTION: Twenty One (21) days.</p>	3 601		