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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: J1L7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00160

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

3. NAME AND ADDRESS OF FACILITY
(L3) **REDEEMER RESIDENCE INC**
(L4) **625 WEST 31ST STREET**
(L5) **MINNEAPOLIS, MN** (L6) **55408**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/21/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **129** (L18)

13.Total Certified Beds **129** (L17)

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Shawn Soucek, HPR SW 01/14/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/14/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/01/2015
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24 5520

On December 21, 2015, the Department of Health completed a Post Certification Revisit (PCR) and on January 11, 2016 the 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 PCR, completed on November 25, 2015 and life safety code survey completed October 20, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 17, 2016. Based on our visits, we have determined that the facility has corrected the remaining deficiencies as of January 11, 2016. As a result that the facility achieved compliance, this Department discontinued the Category 1 remedy of State Monitoring as of January 11, 2016.

In addition, we recommended to the CMS Region V Office the following action related to the imposed remedy in our letter of December 2, 2015:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 15, 2016, be rescinded. (42 CFR 488.417 (b))

Since the facility achieved compliance prior to denial of payment going into effect, The two year loss of NATCEP to begin January 15, 2016, is also rescinded. Refer to the CMS 2567b forms for both health and life safety code for the results of this visit.

Effective January 11, 2016, the facility is certified for 129 skilled nursing facility beds.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245520

January 14, 2016

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

Dear Mr. Colgan:

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

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

Effective January 11, 2016 the above facility is certified for:

129 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

Mark Meath

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 14, 2016

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

RE: Project Number S55200026

Dear Mr. Colgan:

On December 2, 2015, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective December 11, 2015. (42 CFR 488.422)

On December 2, 2015, this Department recommended to the Centers for Medicare and Medicaid Services (CMS), CMS concurred and imposed the following remedy and authorized this Department to notify you of the imposition:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 15, 2016. (42 CFR 488.417 (b))

Also, this Department notified you in our letter of December 2, 2015, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 15, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on October 15, 2015, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on November 25, 2015. The most serious deficiencies at the time of the revisit were found 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 December 21, 2015, the Minnesota Department of Health completed a PCR and on January 11, 2016 the 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 PCR, completed on November 25, 2015 and life safety code survey completed October 20, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 17, 2016. Based on our visits, we have determined that your facility has corrected the deficiencies issued

pursuant to our PCR, completed on November 25, 2015 and life safety code survey completed on October 20, 2105, as of January 11, 2016.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective January 11, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of December 2, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 15, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective January 15, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective January 15, 2016, is to be rescinded.

In our letter of November 25, 2015, we advised you that, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 15, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on January 11, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245520	A. Building B. Wing	12/21/2015

Name of Facility	Street Address, City, State, Zip Code
REDEEMER RESIDENCE INC	625 WEST 31ST STREET MINNEAPOLIS, MN 55408

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**12/21/2015**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GL/mm	01/12/2016	30923	12/21/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/15/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245520	A. Building B. Wing **01 - BUILDING 01**	1/11/2016

Name of Facility	Street Address, City, State, Zip Code
REDEEMER RESIDENCE INC	625 WEST 31ST STREET MINNEAPOLIS, MN 55408

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **10/21/2015**	ID Prefix	Correction Completed **11/24/2015**	ID Prefix	Correction Completed **10/23/2015**
Reg. # **NFPA 101** LSC K0025		Reg. # **NFPA 101** LSC K0050		Reg. # **NFPA 101** LSC K0052	
ID Prefix	Correction Completed **01/11/2016**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0054		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	TL/mm	01/12/2016	19251	01/11/2016
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/20/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: J1L7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00160

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

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

3. NAME AND ADDRESS OF FACILITY
(L3) **REDEEMER RESIDENCE INC**
(L4) **625 WEST 31ST STREET**
(L5) **MINNEAPOLIS, MN** (L6) **55408**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/24/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **129** (L18)

13.Total Certified Beds **129** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Conrad Simba, HFE NEII — 12/02/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 01/08/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/01/2015
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5520

On November 24, 2015 a health Post Certification Revisit (PCR) was completed at this facility. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 24, 2015. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on October 15, 2015. The deficiency not corrected is as follows:

F0431 -- S/S: D -- 483.60(b), (d), (e) -- Drug Records, Label/store Drugs & Biologicals

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

• State Monitoring effective December 11, 2015. (42 CFR 488.422)

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 15, 2016. (42 CFR 488.417 (b))

If DPNA goes into effect the facilty would be subject to a two year loss of NATCEP, beginning January 15, 2016.

Refer to the CMS 2567 along with the facilitys plan of correction and CMS 2567b. Post Certification Revisit to follow.

Minnesota Department of Health

Electronically delivered
December 2, 2015

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

RE: Project Number S5520026

Dear Mr. Colgan:

On November 3, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 15, 2015. 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 November 25, 2015, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 15, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 24, 2015. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on October 15, 2015. The deficiency not corrected is as follows:

F0431 -- S/S: D -- 483.60(b), (d), (e) -- Drug Records, Label/store Drugs & Biologicals

The most serious deficiencies in your facility were found 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.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective December 11, 2015. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 15, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective January 15, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 15, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Redeemer Residence Inc is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 15, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

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

Jan.Suzuki@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gayle.lantto@state.mn.us

Phone: (651) 201-3794
Fax: (651) 215-9697

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 itseffectiveness. 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 remedy be imposed:

- 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 15, 2016 (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:

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
Phone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	R 11/25/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on November 25, 2015. The certification tags that were corrected can be found on the CMS 2567B. Also there was one uncorrected deficiency at the time of onsite PCR which can be found on the CMS 2567. 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 will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 431} SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	{F 431}		12/14/15

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

Electronically Signed | 12/10/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	R 11/25/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 431}	Continued From page 1 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were securely stored in 1 of 6 medication carts to minimize the risk of unintentional ingestion and/or potential drug diversion. This has the potential to affect 24 residents on the unit, as well as unauthorized staff or visitors. Findings include: On 11/24/15, at 11:18 a.m. as the surveyor was waiting to observe the medication storage on the 3 east unit, three residents passed by an the unattended medication cart. No nurse was in the area, however, the pastor was visiting in the area with several residents. A short time later a registered nurse (RN)-A came toward the area and reported the licensed practical nurse (LPN)-A was assigned to the unit, but probably was on a	{F 431}	It is the practice of the facility to store all medications and biologicals in locked compartments under proper temperature controls. In addition, to assign medication access keys and to permit only authorized personnel to have access to medication carts and med storage rooms. LPN-A had inadvertently left his med cart unattended to assist with a resident and upon his return was immediately re-educated on the proper procedures of securing the med cart and medication storage on 11/24/2015. Nurses and TMAs were re-educated on facility policy for medication storage. Random medication storage audits will be completed at least weekly. Audit results reviewed by the QA team to determine	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	R 11/25/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 431}	Continued From page 2 break. RN-A and the surveyor both observed a ring of keys and a cup containing two pills was left on top of the unattended cart. RN-A explained the nurse should not have left the keys to the medication cart and medications when leaving the area. RN-A verified the medication was erythromycin (antibiotic medication) and that keys were to unlock the medication cart were residents' medication, including controlled medications were stored. RN-A placed the key into the lock and turned the key, unlocking the cart, and then overhead paged LPN-A to return to the unit. Within a minute LPN-A called the unit, and then returned a short time later. LPN-A explained he had been helping a resident in the shower on the 3 west hallway and had only been off the unit three minutes. LPN-A verified he left the medication cart unattended with medications and the medication keys on top of it when he left the unit. Later at 2:22 p.m. LPN-A was asked if he had left the cart because of an emergency situation on 3 west. LPN-A explained he left the unit because LPN-B called him asking for help, as R34 wanted to change bath days. LPN-B was then interviewed at 2:26 p.m. LPN-B stated she received a phone call from R34 who wanted to speak to the nurse on 3 east about switching his bath day. LPN-B said as soon as she gave R34 the phone number to the 3 east unit, she saw LPN-A coming from the direction of the elevator. She then informed LPN-A R34 wanted to switch his bath day. A follow up interview at 3:06 p.m. with RN-A she said LPN-A was on the 3 west unit walking by LPN-B when she stopped LPN-B to inform him R34 wanted his bath day changed. She verified it	{F 431}	frequency and duration of audits. Responsible for compliance: Nurse Managers and Staff Education. Responsible for overall compliance: Director of Nursing Completion date: 12/14/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	R 11/25/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 431}	Continued From page 3 had not been an emergency situation, and she was unsure how long LPN-A left the cart and medicaiton unattended. RN-A verified unit 3 east had 24 residents residing on the unit, and 20 of the 24 would have been capable of using the keys to open the medicaiton cart. The facility's plan of correction for medicaiton storage indicated appropriate staff would re-education related to medication storage. Both LPN-A and LPN-B attended the re-education inservice on 11/4/15. The facility's 1/27/15, Medication Storage In The Facility policy indicated "medication rooms, carts, and supplies are locked and only licensed nurse, the consultant pharmacist ... are allowed access to medications. Each nurse authorized to use the medicine room or cart keys must carry these keys at all times when on duty."	{F 431}		

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245520	A. Building B. Wing	11/25/2015

Name of Facility	Street Address, City, State, Zip Code
REDEEMER RESIDENCE INC	625 WEST 31ST STREET MINNEAPOLIS, MN 55408

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **11/24/2015**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **11/24/2015**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **11/24/2015**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **11/24/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **11/24/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **11/24/2015**
ID Prefix **F0364** Reg. # **483.35(d)(1)-(2)** LSC	Correction Completed **11/24/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **11/24/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GL/mm	11/30/2015	35574	11/25/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/15/2015			

Minnesota Department of Health

Electronically delivered

December 4, 2015

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

Re: Reinspection Results - Project Number S5520026

Dear Mr. Colgan:

On November 25, 2015 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 October 15, 2015, with orders received by you on November 5, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00160	A. BUILDING: _____ B. WING _____	R 11/25/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Initial Comments *****ATTENTION****** NH 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: On November 25, 2015, surveyors of the Minnesota Department of Health completed an on-site licensing revisit to follow up on licensing orders issued as a result of a licensing survey completed on October 15, 2015. All licensing orders were found in compliance with state regulations.	{2 000}		

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

Electronically Signed | 12/10/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00160	A. BUILDING: _____ B. WING _____	R 11/25/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Continued From page 1 This facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{2 000}		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00160	A. Building B. Wing	11/25/2015

Name of Facility	Street Address, City, State, Zip Code
REDEEMER RESIDENCE INC	625 WEST 31ST STREET MINNEAPOLIS, MN 55408

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 **20265** Reg. # **MN Rule 4658.0085** LSC	Correction Completed **11/24/2015**	ID Prefix **20555** Reg. # **MN Rule 4658.0405 Subp. 1** LSC	Correction Completed **11/24/2015**	ID Prefix **20840** Reg. # **MN Rule 4658.0520 Subp. 2 B** LSC	Correction Completed **11/24/2015**
ID Prefix **20845** Reg. # **MN Rule 4658.0520 Subp. 2 C** LSC	Correction Completed **11/24/2015**	ID Prefix **20960** Reg. # **MN Rule 4658.0600 Subp. 1** LSC	Correction Completed **11/24/2015**	ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp. 1** LSC	Correction Completed **11/24/2015**
ID Prefix **21565** Reg. # **MN Rule 4658.1325 Subp. 4** LSC	Correction Completed **11/24/2015**	ID Prefix **21990** Reg. # **MN St. Statute 626.557 Subd. 4** LSC	Correction Completed **11/24/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/mm	11/30/2015	35574	11/25/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/15/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: J1L7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00160

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

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

3. NAME AND ADDRESS OF FACILITY
(L3) **REDEEMER RESIDENCE INC**
(L4) **625 WEST 31ST STREET**
(L5) **MINNEAPOLIS, MN** (L6) **55408**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/15/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **129** (L18)

13.Total Certified Beds **129** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Shawn Soucek, HPR SWS 11/23/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 11/30/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

Certified Mail # 7015 0640 0003 5695 5002

November 3, 2015

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

RE: Project Number S5520026

Dear Mr. Colgan:

On October 15, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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;

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D 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: gayle.lantto@state.mn.us

Phone: (651) 201-3794
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 24, 2015, 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 November 24, 2015 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 15, 2016 (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 April 15, 2016 (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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

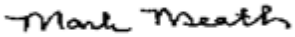
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

Phone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	10/15/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157		11/24/15

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

Electronically Signed | 11/14/2015

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F 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify a responsible party of a fall shortly after admission for 1 of 1 resident (R175) whose family member reported lack of notification. Findings include: R175's family member (FM)-A was interviewed on 10/12/15, at 1:40 p.m. FM-A reported R175 had experienced a fall on "Friday," however, she had only learned of the information when she came to visit "today" (Monday). She confirmed she was the responsible party for R175. R175's nurse's note revealed the resident had been admitted on 10/9/15 at 7:11 p.m. looking "frail and cachectic [in ill-health]." She was instructed to use the call light if she needed help, and the bed was in the lowest position. A fall report also dated 10/9/15, at 7:38 p.m. revealed R175 was "found prone [face down] on the floor at around 1845 [6:45 p.m.], stated, 'I don't know what happened, I fell.' Resident showed some confusion and no agitation. No	F 157	This response and plan of correction are not admissions to or an agreement that a deficiency exists or that the statement of a deficiency was correctly cited or factually based. It is the facility's practice to notify the residents¿ primary contact with all fall incidents. R175 primary contact was notified of the fall on 10/12/2015. Nurse responsible for contacting R175 family has been re-educated. Random Audits of fall incidents will be completed to ensure the appropriate person has been contacted. Results will be reviewed by the QA team to determine duration and frequency of audits. Responsible for compliance: Nurse Managers Responsible for overall compliance: Director of Nursing	

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F 157	Continued From page 2	F 157		

injuries, bleeding, contusion, abrasion or hematoma [bruising, scrapes, or swelling filled with blood] noted on head. Assisted to bed, will be monitored throughout the night."

A registered nurse (RN)-D was interviewed on 10/14/15, at 3:26 p.m. RN-D reported RN-E was on duty and had notified the family of R175's fall on 10/9/15, at 8:20 p.m.

A Safety Events form dated 10/09/15 indicated RN-E notified R175's family at "2030" (8:30 p.m.).

A follow up telephone call was placed to FM-A on 10/15/15, at 10:23 a.m. FM-A reported she arrived at the facility to visit R175 on 10/12/15, at approximately 10:30 a.m. During her visit her told her she had experienced a fall. She then inquired with the nurse who was working that day, who verified her mother indeed had fallen on 10/9/15. When told it was documented a nurse called her the day of the fall she emphatically replied, "That's a lie," and said no message had been left on either her home or cell phone.

In a follow up interview with RN-D at 10:30 a.m. he stated he had contacted RN-E who documented family notification the fall. The nurse verified he had not actually contacted R175's family. RN-D thought the nurse probably intended to contact R175's family, but then forgot. RN-D, the nurse manager of the unit, stated he expected family to be called regarding all falls.

The facility's 9/11, Fall Management Policy--Protocol for Investigation of a Fall directed licensed nurses to contact family member/designated person.

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F 176	Continued From page 3	F 176		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure self-administration of medications was a safe practice for 1 of 1 resident (R132) observed with medications left at the bedside. Findings include: R132 was observed on 10/15/15, at 1:29 p.m. while sitting in a recliner in her room. The resident was whimpering. A medicine cup containing five pills was on the footrest in front of her, and another pill was outside the cup on the footrest. R132 verified the pills were hers, and that she was in pain. The surveyor immediately summoned the director of nursing (DON) and a registered nurse. RN-D verified R132 was only allowed to self-administer topical medications. RN-D then discovered R132 had declined taking the medications, but said the nurse should not have left R132 with the medications. The Self-Administration of Medication assessment for R132 dated 5/5/15, revealed the resident was capable of administering a topical medication that was left in her room for	F 176	The facilities practice is that an individual may self-administer drugs if the inter-disciplinary team has determined that this practice is safe. R132 was discharged on 11/2/2015. Nurses were educated on the self-administration of medication (SAM) policy and requirements. Nurses will report new requests to the nurse manager who will then ensure requirements have been met prior to the resident self-administering medications. Random medication pass audits will be completed by facility and continue to be completed by consultant pharmacy. Responsible for compliance: Nurse Managers Responsible for overall compliance: Director of Nursing	11/24/15

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F 176	Continued From page 4 self-administration. R132's care plan dated 5/5/15, indicated a Self-Administration of Medication assessment was to be completed prior to allowing the resident to self-administrate medications. The care plan noted R132 could, however, self-administer the topical medication. A 1/13, Medication-Self Administration policy indicated "All medications must be administered by facility staff until their ability to self administer has been assessed. Staff must obtain an order from the physician for a resident to self administer and the care plan is to be updated."	F 176		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		11/24/15

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F 225	Continued From page 5 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the administrator and designated State agency (SA) and to thoroughly investigate allegations of verbal abuse for 2 of 2 residents (R174, R48). Findings include: R174 reported he was not treated with dignity and respect by a nursing assistant (NA), during an interview on 10/13/15, at 3:03 p.m. The resident physically described the NA. He stated the incident happened the morning of 10/11/15 during morning cares. The resident said the NA had a "poor attitude...When she was changing my diapers she made a comment to demean me, 'What is all that white stuff coming out?'" When the resident coughed she told him to "Put your hand across your mouth!" She then turned the the other nursing assistant (NA)-A and stated she had told him to cover his mouth before and added, "He probably has TB [tuberculosis]. He	F 225	It is the practice of the facility to ensure all employees have the proper background checks and are clear to work in a healthcare facility. It is also the practice of the facility to follow the mandated procedures regarding vulnerable adults. In regards to the OHFC report for R174, it was filed on 10/15/2015, the nursing assistant involved in the allegation was removed from the schedule, and an investigation summary was submitted within 5 days of the incident report as required. LSW who was made aware of the incident for R174 on 10/14/2015 has been re-educated on the need to report resident allegation of verbal abuse immediately. R48 had a report filed within 24 hours of incident and investigative summary filed with OHFC within 5 days of report due to a report of verbal abuse.	

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F 225	Continued From page 6 should be checked for that." R174 said the NA had made other demeaning remarks in the past and had been indifferent toward him. He stated he had not reported it to anyone, but it "made me feel small...I didn't reply, because I realize you cannot talk to ignorance like that." During a second conversation on 10/14/15, at 12:50 p.m. R174 stated he reported the incident to the social worker earlier that day because he felt he had been abused verbally by NA-A. An interview with a licensed social worker (LSW) on 10/15/15, at 8:16 a.m. revealed R174 had told her first on 10/12/15 regarding the incident during their initial visit. The LSW stated R174 did not like the way the NA-A made him feel but did not consider this to be abuse. She further explained R174 spoke to her again on 10/14/15 regarding his treatment and this time stated he felt he was verbally abused by NA-A. The LSW stated she brought it to the attention of the corporate representative and was told it was not a reportable incident. An investigation was not initiated at this time. At 8:33 a.m. the same day another NA was interviewed. NA-B stated on 10/12/15, during morning rounds NA-A asked for assistance with providing care for R174. While they were assisting R174, NA-A removed his incontinent brief and asked R174 "What is all that yucky white stuff in there [incontinent brief]?" NA-B explained is was the cream they had applied to his skin for protection. NA-A then stated "He was so bad this morning, he was like an asshole" (because he was anxious and kept turning on his light). She added NA-A had made these statements in the presence of the resident, and	F 225	Staff have been re-educated on the need to report immediately. Staff completing OHFC investigations were re-educated on need to include dates and times of interviews conducted during the investigations. All staff are educated upon hire, annually, and prn on vulnerable adult reporting. Responsible for Compliance: Director of Nursing and Administrator	

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F 225	Continued From page 7	F 225		

portrayed this type of demeanor often. NA-B stated she had reported the situation to RN-F.

At 8:49 a.m. R174 stated when he first reported the abuse on Monday he did not consider it as abuse but later he did. He reported it to the LSW as abuse and stated it made him "feel insignificant."

At 8:59 a.m. while explaining the incident the director of nursing (DON) verified with the incident was reported by the LSW at that time. She further explained she would have expected an incident of reported abuse to be reported to the SA immediately. "This should have been reported yesterday. It is our policy."

At approximately 9:32 a.m., RN-D explained RN-F was not in the facility but spoke to her by phone. She did not recall NA-B reporting the incident.

Later that day at 10:02 a.m. the DON stated she spoke with the corporate representative and verified the LSW had brought the allegation to her attention, but did not feel it was a reportable incident.

R174 was newly admitted to the facility with diagnoses including anxiety. A Brief interview for Mental Status score dated 10/12/15, revealed intact cognition (15/15 possible).

Nursing progress notes were reviewed but lacked mention of this incident.

A request for all incident reports for R174 was requested but was not provided.

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F 225	Continued From page 8 R48's incident report was submitted to the SA on 8/26/15, which revealed NA-Y reported NA-Z swore at the resident during evening cares on 8/25/15. R48 could not recall the event. A documented interview in the investigative file dated 8/26/15, revealed NA-Y did not report the incident to a supervisor until the following day. The investigative report was not submitted to the SA until 8/31/15, and lacked interviews of appropriate persons to determine their potential knowledge of the incident or similar allegations. The report did not include a rationale as to why the report was not made by NA-Y until the following day, nor measures taken to ensure NA-Y reported immediately in the future. R48's Minimum Data Set (MDS) dated 8/12/15, revealed the resident had short and long term memory problems and required staff extensive staff assistance for cares such as bed mobility, personal hygiene, dressing, toileting, and transferring. On 10/15/15, at 12:27 p.m. the director of nursing (DON) reported NA-Y may have delayed reporting because the incident did not occur until the end of her shift. The DON reported she would have expected allegations to be immediately reported. Although she had spoken to NA-Y about immediate reporting, she had not documented the conversation. The DON explained a previous manager had completed the investigation into R48's allegation, and believed appropriate persons had been interviewed, but again, had not been documented. The DON verified other residents or their family members and staff persons should have been interviewed	F 225		

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	245520	A. BUILDING _____ B. WING _____	10/15/2015

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REDEEMER RESIDENCE INC	625 WEST 31ST STREET MINNEAPOLIS, MN 55408

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F 225	Continued From page 9	F 225		

about their knowledge of how residents were being treated and/or their knowledge of potential similar allegations. The DON reported she would review NA-Y's employee file regarding immediate reporting of allegations and check to see if any other investigative information was available related to R48.

The facility's 9/13, Vulnerable Adult Abuse Prohibition Plan directed staff: "Each employee is responsible to report suspected/alleged violations of mistreatment, neglect, and abuse of residents and/or misappropriation of resident property immediately to one of the following: Nursing Supervisor, Nurse on Duty, Director of Nursing or Social Worker. The administrator will be notified immediately by one of the above. Staff may go immediately to the Administrator if desired. Report all alleged violations and substantiated incidents immediately to the SA and all other agencies as required...Identify events, such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse and determine the direction of the investigation...1. All reports of suspected/alleged resident abuse, neglect, mistreatment, injuries of unknown source and/or misappropriation of resident property shall be promptly and thoroughly investigated. 2. Collect data and document investigative findings. 3. The investigation may include but is not limited to: physical examination of the resident and environment. Examination of the resident by a licensed nurse or physician. IF sexual abuse is suspected, call the police immediately. DO NOT bathe/wash the resident or wash the resident's clothing or linen. Do not take items from the area in which the incident occurred. Review documentation and the resident's medial record

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F 225	Continued From page 10 for events leading up to incident. Interview the person(s) reporting the incident. Interview the alleged victim. Interview any potential witness to the incident. Interview the alleged perpetrator. Interview other residents to whom the alleged perpetrator provides care or services. Review the completed documentation."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow abuse prohibition policies and report immediately to the administrator and designated State agency (SA) and thoroughly investigate allegations of verbal abuse for 2 of 2 residents reviewed (R174, R48); and failed to ensure background checks were completed before 3 of 18 newly hired employees provided direct care services to residents. Findings include: The facility's 9/13, Vulnerable Adult Abuse Prohibition Plan directed staff: "Each employee is responsible to report suspected/alleged violations of mistreatment, neglect, and abuse of residents and/or misappropriation of resident property immediately to one of the following: Nursing Supervisor, Nurse on Duty, Director of Nursing or	F 226	It is the practice of the facility to follow the mandated reporting procedures as it relates to Vulnerable Adults. When an incident is of known origin, per VA guidelines, it is not reportable as an unknown incident. Such was the case with R73. It is also the practice of the facility to conduct background checks on all employees prior to allowing them to work unsupervised within the facility. Regarding R48, a report was filed within 24 hours of incident and per reporting guidelines an investigative summary filed with OHFC within 5 days of report due to a report of verbal abuse. Staff have been re-educated on the	11/24/15

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F 226	Continued From page 11 Social Worker. The administrator will be notified immediately by one of the above. Staff may go immediately to the Administrator if desired. Report all alleged violations and substantiated incidents immediately to the SA and all other agencies as required...Identify events, such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse and determine the direction of the investigation...1. All reports of suspected/alleged resident abuse, neglect, mistreatment, injuries of unknown source and/or misappropriation of resident property shall be promptly and thoroughly investigated. 2. Collect data and document investigative findings. 3. The investigation may include but is not limited to: physical examination of the resident and environment. Examination of the resident by a licensed nurse or physician. IF sexual abuse is suspected, call the police immediately. DO NOT bathe/wash the resident or wash the resident's clothing or linen. Do not take items from the area in which the incident occurred. Review documentation and the resident's medial record for events leading up to incident. Interview the person(s) reporting the incident. Interview the alleged victim. Interview any potential witness to the incident. Interview the alleged perpetrator. Interview other residents to whom the alleged perpetrator provides care or services. Review the completed documentation." In addition, the policy directed, "Screen all potential employees for a history of abuse, neglect, mistreatment, and misappropriation of resident property during the hiring process. Screening will consist of, but not limited to: Criminal background checks." R174 reported he was not treated with dignity and respect by a nursing assistant (NA), during an	F 226	protocol to immediately report VA concerns and to include dates and times of investigative interviews was conducted in October, November and is on-going. All staff are educated upon hire, annually, and prn on vulnerable adult reporting. Responsible for compliance: Managers, DON, and Administrator Regarding employee background checks, the procedure as been revised and staff educated on the proper timing and supervision guidelines. Responsible persons: HR Manager, managers and Administrator.	

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interview on 10/13/15, at 3:03 p.m. The resident physically described the NA. He stated the incident happened the morning of 10/11/15 during morning cares. The resident said the NA had a "poor attitude...When she was changing my diapers she made a comment to demean me, 'What is all that white stuff coming out?.'" When the resident coughed she told him to "Put your hand across your mouth!" She then turned the the other nursing assistant (NA)-A and stated she had told him to cover his mouth before and added, "He probably has TB [tuberculosis]. He should be checked for that." R174 said the NA had made other demeaning remarks in the past and had been indifferent toward him. He stated he had not reported it to anyone, but it "made me feel small...I didn't reply, because I realize you cannot talk to ignorance like that."

During a second conversation on 10/14/15, at 12:50 p.m. R174 stated he reported the incident to the social worker earlier that day because he felt he had been abused verbally by NA-A.

An interview with a licensed social worker (LSW) on 10/15/15, at 8:16 a.m., revealed R174 had told her first on 10/12/15 regarding the incident during their initial visit. The LSW stated R174 did not like the way the NA-A made him feel but did not consider this to be abuse. She further explained R174 spoke to her again on 10/14/15 regarding his treatment and this time stated he felt he was verbally abused by NA-A. The LSW stated she brought it to the attention of the corporate representative and was told it was not a reportable incident. An investigation was not initiated at this time.

At 8:33 a.m. the same day another NA was

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interviewed. NA-B stated on 10/12/15, during morning rounds NA-A asked for assistance with providing care for R174. While they were assisting R174 , NA-A removed his incontinent brief and asked R174 "What is all that yucky white stuff in there [incontinent brief]?" NA-B explained is was the cream they had applied to his skin for protection. NA-A then stated "He was so bad this morning, he was like an asshole" (because he was anxious and kept turning on his light). She added NA-A had made these statements in the presence of the resident, and portrayed this type of demeanor often. NA-B stated she had reported the situation to RN-F.

At 8:49 a.m. R174 stated when he first reported the abuse on Monday he did not consider it as abuse but later he did. He reported it to the LSW as abuse and stated it made him "feel insignificant."

At 8:59 a.m. while explaining the incident the director of nursing (DON)the LSW was reporting the incident at that time. She further explained she would have expected an incident of reported abuse to be reported to the SA immediately. "This should have been reported yesterday. It is our policy."

At approximately 9:32 a.m., RN-D explained RN-F was not in the facility but spoke to her by phone. She did not recall NA-B reporting the incident.

Later that day at 10:02 a.m. the DON stated she spoke with the corporate representative and verified the LSW had brought the allegation to her attention, but did not feel it was a reportable incident.

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R174 was newly admitted to the facility with diagnoses including anxiety. A Brief interview for Mental Status score dated 10/12/15, revealed intact cognition (15/15 possible).

Nursing progress notes were reviewed but lacked mention of this incident.

A request for all incident reports for R174 was requested but was not provided.

R48's incident report was submitted to the SA on 8/26/15, which revealed NA-Y reported NA-Z swore at the resident during evening cares on 8/25/15. R48 could not recall the event.

A documented interview in the investigative file dated 8/26/15, revealed NA-Y did not report the incident to a supervisor until the following day. The investigative report was not submitted to the SA until 8/31/15, and lacked interviews of appropriate persons to determine their potential knowledge of the incident or similar allegations. The report did not include a rationale as to why the report was not made by NA-Y until the following day, nor measures taken to ensure NA-Y reported immediately in the future.

R48's Minimum Data Set (MDS) dated 8/12/15, revealed the resident had short and long term memory problems and required staff extensive staff assistance for cares such as bed mobility, personal hygiene, dressing, toileting, and transferring.

On 10/15/15, at 12:27 p.m. the director of nursing (DON) reported NA-Y may have delayed reporting because the incident did not occur until

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the end of her shift. The DON reported she would have expected allegations to be immediately reported. Although she had spoken to NA-Y about immediate reporting, she had not documented the conversation. The DON explained a previous manager had completed the investigation into R48's allegation, and believed appropriate persons had been interviewed, but again, had not been documented. The DON verified other residents or their family members and staff persons should have been interviewed about their knowledge as to how residents were being treated and/or their knowledge of potential similar allegations. The DON reported she would review NA-Y's employee file regarding immediate reporting of allegations and check to see if any other investigative information was available related to R48.

Review of E1's employee file revealed E1 started working at the facility on 7/9/15. E1's background check was completed on 8/31/15, verifying E1 "may provide direct contact services for the facility without continuous supervision." The daily schedule revealed E1 worked under continuous supervision by another staff member from 7/9/15 until 7/22/15, and then worked in her position without direct supervision from another staff. Review of the time detail report revealed E1 worked 19 shifts without continuous supervision between 7/22/15 until she passed her background check on 8/31/15.

Review of E2's employee file revealed E2 started working at the facility on 8/4/15. E1's background check was completed on 9/1/15 verifying E2 "may provide direct contact services for the facility without continuous supervision." The daily schedule revealed E2 worked under continuous

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F 226	Continued From page 16 supervision by another staff member from 8/4/15 until 8/14/15. Review of the time detail report revealed E2 worked nine shifts without continuous supervision until background check results came back on 9/1/15. Review of E3's employee file revealed E3 started working at the facility on 8/18/15. E1's background check was completed on 9/3/15, verifying the employee "may provide direct contact services for the facility without continuous supervision." The daily schedule revealed E3 worked under continuous supervision by another staff member from 8/18/15 until 8/31/15. Review of the time detail report revealed E3 worked 1 shift without continuous supervision until she passed her background check on 9/3/15. On 10/14/15, at 3:04 p.m. the human resource worker verified E1, E2 and E3 worked at the facility providing direct care services to residents without continuous supervision prior to their background checks being complete.	F 226		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	F 279		11/24/15

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F 279	Continued From page 17 to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a care plan was developed for 1 of 3 residents (R59) reviewed for activities of daily living. Findings include: R59's care plan lacked direction to staff as to how to ensure the resident was kept clean and odor free. The plan lacked identification of her dependence on staff for personal hygiene and bathing. An incontinence care plan noted the resident was at risk for incontinence. R59 was observed in her room on 10/12/15, at 1:30 p.m. Her was appeared greasy and was uncombed. A strong smell of urine was detected in the room. On 10/13,14, at 12:30 p.m. and 5:30 p.m. there was no change in the resident's appearance and a urine odor was present. On 10/14/13, at 8:30 a.m. during an interview R59, she stated the staff helped her with her incontinent issues to change and clean up, as well as with weekly showering and washing her face each day. She was satisfied with her bathing routine. The resident again had	F 279	It is the facilities practice to use the results of the assessment to develop, review and revise the resident¿s comprehensive plan of care. R59 had an ADL care plan developed and in place on 10/15/2015. An audit was completed on 10/19/2015 for all other residents in the facility to ensure an ADL care plan was in place for each. Random audits will be completed for new admissions to ensure an ADL care plan is in place by day 21 of their nursing home stay. Quality Assurance Committee will review audit results and determine frequency and duration of audits. Responsible for compliance: Nurse Managers Responsible for overall compliance: Director of Nursing	

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F 279	Continued From page 18 greasy/uncombed hair and smelled of urine. The following day at 8:45 a.m. the resident's hair was still unclean and uncombed and a urine odor was noted. At that time the resident reported she did not know when her scheduled bath day. R59's quarterly Minimum Data Set (MDS) revealed the resident was cognitively intact, and required extensive assistance with dressing, toilet use, and personal hygiene. She was noted as always incontinent of urine. The bathing portion of the assessment read, "Activity itself did not occur during the entire period." The resident did not resist care during the assessment period. On 10/15/15, at 9:30 a.m. a registered nurse (RN)-B reviewed the care plan and verified ADLs was not included in the plan, but should have been. A related policy was requested, but was not provided.	F 279		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide hygiene services to ensure residents were kept clean and odor free for 1 of 3 residents (R59) who were	F 312	It is the facility's policy that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	11/24/15

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F 312	Continued From page 19 dependent on staff and were reviewed for activities of daily living (ADLs). Findings include: R59 was observed in her room on 10/12/15, at 1:30 p.m. Her was appeared greasy and was uncombed. A strong smell of urine was detected in the room. On 10/13,14, at 12:30 p.m. and 5:30 p.m. there was no change in the resident's appearance and a urine odor was present. On 10/14/13, at 8:30 a.m. during an interview R59, she stated the staff helped her with her incontinent issues to change and clean up, as well as with weekly showering and washing her face each day. She was satisfied with her bathing routine. The resident again had greasy/uncombed hair and smelled of urine. The following day at 8:45 a.m. the resident's hair was still unclean and uncombed and a urine odor was noted. At that time the resident reported she did not know when her scheduled bath day. R59's quarterly Minimum Data Set (MDS) revealed the resident was cognitively intact, and required extensive assistance with dressing, toilet use, and personal hygiene. She was noted as always incontinent of urine. The bathing portion of the assessment read, "Activity itself did not occur during the entire period." The resident did not resist care during the assessment period. The care plan for R59 lacked direction to staff as to how to ensure the resident was kept clean and odor free. The plan lacked identification of her dependence on staff for personal hygiene and bathing. An incontinence care plan noted the resident was at risk for incontinence.	F 312	personal and oral hygiene. R59 had directions on the nursing assistants' group sheet to provide staff assist with ADL care and this is now included on the resident's care plan. Care plan was put into place on 10/15/2015. Random ADL audits to be completed weekly. Quality Assurance Committee will review audit results and determine frequency and duration of audits. Responsible for compliance: Nurse Managers Responsible for overall compliance: Director of Nursing	

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F 312	Continued From page 20 On 10/15/15, at 9:30 a.m. a registered nurse (RN)-B reported she was unaware R59 smelled of urine and that her hair was unclean and uncombed. She said the staff was responsible for ensuring R59 was assisted with incontinence care and to maintain good hygiene. A related policy was requested, but was not provided.	F 312		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure food was served at palatable temperatures for 1 of 1 resident (R160) who requested food reheated and potentially the other 14 residents in the 2W dining room. Findings include: Noon meal observations were conducted on 10/12/15, at 12:00 p.m. in the 2W dining room. A dietary aide (DA)-A entered the dining room with two metal food warmers that had food containers covered with foil, but no metal covers. DA-A then plugged in the food warmers, and instead of partially leaving the food covered to ensure	F 364	It is the practice of the facility to provide and to ensure that meals are nutritious and flavorful and served at the proper temperatures. To ensure food is held and served at the proper temperatures, staff will utilize the appropriate equipment to hold and transport food items. Temperature checks will be done to ensure holding and serving tempts are at appropriate levels. Weekly meal audits and resident interviews will be conducted to assess food palatability and proper temperatures. Audits will be conducted for six weeks to then be re-evaluated as to their frequency and scope. Staff will offer to reheat food as necessary and residents	11/24/15

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F 364	Continued From page 21 maximum temperatures were maintained, the foil covers were removed. Temperatures were then taken of the individual foods. When taking the temperatures, however, a click was heard as the metal probe touched the bottom of the pan. DA-A stated it was the way he usually measured food temperatures with the probe on the bottom of the pan. The corn registered 120 degrees Fahrenheit (F), and chicken noodle and tomato soup registered 140 degrees. DA-A reported the hot foods should have registered 160 degrees, and if they did not he heated foods when residents asked for food to be re-heated. At 12:19 p.m. R160 stood up and took her plate of food from the table to the microwave in the room to re-heat her food. A discussion then took place between DA-A and a nursing assistant as to how long the food needed to be microwaved. A staff person then assisted the resident to reheat the plate of food. R160 explained to the surveyor, "My meat was not warm." The surveyor asked DA-A to measure the temperature of the R160's pork rib and it registered 120 degrees after being heated in the microwave for one minute. DA-A then proceeded to reheat R160's pork riblets, potatoes, and mixed vegetables a second time in the microwave for two minutes before reserving to R160. A second pan of pork riblets covered with foil was hand carried up from the kitchen. The riblets registered 130 degrees, and DA-A proceeded to individually microwave each plate served of riblets, potatoes and mixed vegetables or corn to the rest of the residents who had not yet been served in the dining room. The food in the warmers was left uncovered throughout the dining service. At 12:25 p.m. mashed potatoes in the food warmers registered 120 degrees and mixed vegetables registered 130 degrees when	F 364	will be reminded that staff are available to reheat food whenever necessary. The Resident Food Committee and Customer Satisfaction surveys will also be utilized to gain feedback from residents as to their level of satisfaction. Audits will be reviewed at Quarterly Q.A. meetings. Dietary staff were re-trained on proper procedures during the week of 10/12/15. Dietary manager is responsible for on-going compliance.	

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temperatures were re-taken. Five minutes later the dining director (DD) reported that the second pan of pork riblets sent to replace the first pan left the kitchen at 170 degrees. The surveyor then informed the DD that the riblets measured 130 degrees after arrival when DA-A measured it. DD stated she did not know whether the riblets had been immediately delivered, or whether there was a delay due to the elevators being busy. She said an announcement had been made over the loudspeaker to keep the elevators free during mealtime.

The following day at 11:41 a.m. R160 reported, "My food is frequently cool--not hot enough. I heat my food up in the microwave quite often...So I guess it is something you have to put up with and do your self." R160 stated she usually was served "right away" and said she was glad the surveyor was present to see the food was not being served hot enough.

At the noon meal at 12:06 p.m. DA-C brought up a food cart with two metal warmers placed on the top with foil coverings. DA-C then plugged in the warmer and proceeded to measure the temperatures of the food. A click was again heard as the probe touched the bottom of the metal pan when the meatloaf temperature was measured. DA-C pulled the foil back from the individual pans and did not partially or re-cover the food. Hamburger registered 120 degrees, chicken legs registered 123 degrees and chicken noodle soup registered 140 degrees. The surveyor reviewed the temperatures after DA-C had recorded the temperatures on a log. The temperatures, however, were written on different columns different from that foods' column. When asked why the temperatures were recorded as they

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were, DA-C replied, "I sometimes write the temperature anywhere as there is no place for it on the log." DA-C also stated only 2W and 3W dining rooms used warmers to transport and serve the food, as the other dining rooms had kitchenettes. When asked about the hamburger and chicken legs temperatures being lower than the policy directed, DA-C explained that she would have warmed the food per resident request.

At 12:32 p.m. DD stated, "Since we talked yesterday, I re-told the staff in morning meeting today to put plastic covers on the warmers" during transport, and to keep the food covered during the meal service. She was unsure why when all staff had been trained, that the covers were not in use in the 2W dining room, but she would continue to monitor the situation. The change from steam tables in the two dining areas to the use of the warmers had started just a year ago, and they had not maintained the Cayenne Vollrath (brand name) manufacturer's instructions.

On 10/14/15, at 8:41 a.m. plastic covers were utilized to cover foods at the breakfast meal. DA-B stated she always used the plastic covers on the warmers, but that dietary staff "work differently" with some dietary staff just covering the food with foil. DA-B also reported she had been taught by the DD to utilize the plastic covers. In addition, they were supposed to ensure the metal probe touched the bottom of the metal pan when taking temperatures, to ensure the entire food was warm. DA-B was unsure whether measuring the metal probe touching the bottom of the pan would potentially erroneously affect the temperature of the food.

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F 364	Continued From page 24 At the noon meal that same day at 12:01 p.m. in the 2W dining room, food warmers were observed being transported with the plastic covers off the pans as much as four to five inches, as there were multiple different shaped pans stacked, thus preventing the covers from fitting snuggly. Three of the eight pans were stacked on lower pans and were not in contact with the hot water intended to keep the food hot. DA-B plugged in the warmers and measured food temperatures. Chicken soup registered 112 degrees and tomato soup registered 118 degrees. When asked about the temperatures DA-B stated, "110 degrees is okay for soup." After the meal DD stated she had trained staff to touch the bottom of the pan with the probe. DD verified the metal pans should have all been directly in contact with the hot water in the warmer. Policies regarding food temperatures and serving was requested but not provided by the facility.	F 364		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 431		11/24/15

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F 431	Continued From page 25 appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure expired medication was not stored for use for 2 of 3 residents (R10, R18) whose Advair Discus inhalers (to aid in breathing) had not been destroyed after they had expired. In addition, insulin pens were not properly refrigerated according to manufacturer's guidelines for 1 of 1 resident (R114) whose insulin was stored at room temperature. Findings include: 1) R10's Advair Discus was opened, undated when opened, and had one dose remaining when	F 431	It is the facilities practice to employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Advair inhalers for R10 and R18 were removed from the medication cart and disposed of on 10/14/2015 during survey. For R114 insulin pens were disposed of and insulin replaced. The only resident on	

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F 431	Continued From page 26 the 2W medication cart was observed for medication storage 10/14/15, at 9:47 a.m. A registered nurse (RN)-A verified there was one dose remaining, and explained R10 utilized the medication twice daily. RN-A reported nursing staff had been trained to date inhalers when they were opened, but was unsure why the Advair lacked an opened date. RN-A was unsure how long the Advair would have been effective once opened, but would use the pharmacy label and if unlabeled, would use the expiration date on the inhaler. 2) R18's Advair Discus was also opened and stored for use on the 2W medication cart, but lacked an opened date. RN-A verified the medication had been opened, but had not been dated when opened. 3) R114's Nov 70/30 and Nov Aspart insulin pens (for diabetes) were unopened, but stored at room temperature on the medication cart versus being refrigerated according to manufacturer's recommendations. RN-A explained at the time of the 2W medication storage observations, "They are supposed to be in the refrigerator [because they had not been opened]...I just took them out of the refrigerator at the beginning of the shift, in case I needed them." RN-A said R114 had blood sugar checks three times daily, and may have needed the medication depending on the readings. A short time later RN-A emerged from the medication room carrying three plastic bags. RN-A said two of the bags contained Advair inhalers for R10 and R18. R10's bag was labeled with a sticker indicating the medication had been opened on 9/9/15, therefore should have been	F 431	the unit with insulin pens had insulin replaced. Nurses responsible for administering the Advair and insulin were re-educated on facility policy for expiration of medications and dating items when opened as indicated. Tuberculin vial noted during survey was destroyed. Random medication storage and medication pass audits will be completed and reviewed monthly by the QA team who will then determine frequency and duration of audits. Responsible for compliance: Nurse Managers and Staff Education. Responsible for overall compliance: Director of Nursing	

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destroyed after 10/8/15. R18's bag had a pharmacy label that read "Dispose after 30 days of opening" and was dated as opened 8/7/15. The medication should have been disposed of after 9/5/15.

4) The next observation was of refrigerated medications on the unit. A multi-use vial of Tubersol (for tuberculin skin testing) was dated as opened 4/11/15. RN-A verified the bottle had been opened and approximately 1/3 of the medication was left in the bottle. RN-A reported she was unaware how long Tubersol could be used once it had been opened, and was unaware of any reference sheet available that would have directed the staff. RN-A stated she would use the expiration date on the bottle. The bottle was dated 3/16, and was stored in a refrigerator with no thermometer. The medication room refrigerator had a thermometer that read 28 degrees Fahrenheit (F). RN-A states she thought the medication could be stored no higher than 40 degrees, but was unsure how the temperature may have affected the medication effectiveness. RN-A said nurses working the night shift were responsible for checking medication refrigerator temperatures.

A laminated listing from the pharmacy was posted at the nursing station. The list noted Advair should have been discarded 30 days after opening.

On 10/14/15, at 2:33 p.m. the director of nursing (DON) stated nurses were to follow the list posted at each nurses station. The list indicated medication efficacy dates for medications with shortened use dates and time frames for disposal. The DON also stated medication

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F 431	Continued From page 28 refrigerators should have been maintained between 36 to 46 degrees. New temperature logs with shaded instructions were going to be added, with instructions as to how to adjust temperatures that were found out of range. The DON then called RN-B, who informed the DON the temperature gauge had already been adjusted. The DON also explained the night nurses were to check the temperatures and day nurses were to check the temperatures if the night nurse had neglected to note the temperature. The temperature log provided by the facility for the 2W medication refrigerator for the month of 10/15 indicated the refrigerator had been out of range at 32 degrees on 10/1/15, and at 34 degrees on 10/2. The undated Merwin LTC Pharmacy Medication Storage and Expiration Guidelines provided by the facility directed staff as follows: "Insulin Pens Unopened--Refrigerator...Tuberculin PPD [for tuberculin testing] Refrigerator Date When Open Expiration Date 30 Days After 1st Use...Advair Discus Date When Open Expiration Date 30 Days After Foil Opened...Refrigerator temperature=36-46 degrees F." A 1/27/15, Medication Storage In The Facility policy indicated, "Medications requiring refrigeration are kept at temperatures ranging from 36-46 degrees F (2-8 degrees C [Celsius]) in a refrigerator not accessible to residents."	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		11/24/15

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F 441	Continued From page 29 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure infection control	F 441	It is the facilities policy to establish and maintain an infection control program	

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F 441	Continued From page 30 procedures were followed to minimize the risk for spread of infection for 1 of 1 resident (R57) observed blood glucose test and additionally affecting a second resident for whom the device was also utilized. In addition, medication was not administered in a sanitary manner for 1 of of 5 residents (R66) whose medication administration was observed. Findings include: R57's blood sugar was checked on 10/14/15, at 11:56 a.m. by a registered nurse (RN)-A. After the check was completed, RN-A used a Sani Wipe germicidal cloth to clean the glucometer for 3-4 seconds, and then set the glucometer on top of the medication cart. RN-A was asked if this was the usual manner for cleaning glucometers. RN-A said it was her usual practice to wipe the glucometer for five seconds before and after use. RN-A also reported the glucometer was used at the current time by two residents. The facility had recently "audited" her on this, and stated it was how she cleaned the glucometer during the auditing process. At 1:05 p.m. a licensed practical nurse (LPN)-B reported she wiped the entire glucometer all over with the Sani Wipe, and then wrapped the Sani Wipe around the glucometer for three seconds. The surveyor then clarified with LPN-B if she indeed meant three seconds and LPN-B again stated, "three seconds." Thirty minutes later, RN-B explained nurses were to clean glucometers after each use "according to the manufacturer's instructions." RN-B then referred to the instructions on the Sani Wipe container and read, "two minutes." RN-B said	F 441	designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. RN-A and LPN-B along with nursing staff have been re-educated on the disinfectant procedure for glucometers and on the proper handling of medications and infection control measures to be used during a medication pass. Random audits of glucometer disinfecting and medication passes will be completed and will be reviewed monthly by the QA Committee who will then determine frequency and duration of audits. Responsible for compliance: Infection control nurse and nurse managers Responsible for overall compliance: Director of Nursing.	

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glucometers should have remained wet by wrapping the wipe around the glucometer and leaving it for two minutes.

At 1:58 p.m. RN-C reported being recently hired at the facility. She stated glucometers should be wiped "real good" and left to air dry. RN-C was unsure how long the glucometer should be wiped or stay wet, and how long it needed to be air dried prior to use on another resident.

R66's calcium/vitamin D3 tablet was administered by RN-A on 10/14/15, at 8:35 a.m. Without washing her hands or using alcohol gel, RN-A cut the tablet with her bare hands. RN-A said it was the usual method she used to break the tablets, and she was unsure how to break the medication in half without touching it. The rationale for breaking the tablet was that it was "easier" for R66 to swallow.

Following the observation, the director of nursing (DON) was interviewed, and said nurses should have followed manufacture's instructions for sanitizing the glucometers, and verified related audits to ensure compliance had been conducted with nurses. The DON further explained it was expected a nurse would not touch a resident's medication with their hands.

A 3/19/12, Blood Glucose Meter Disinfection policy directed staff as follows: "Purpose: To maintain cleanliness of blood glucose meter (glucometer) and prevent cross-contamination with blood-borne pathogens between each resident use...Disinfect the blood glucose meter: a. Remove the EPA [Environmental Protection Agency] approved disinfectant wipe from container. b. Wipe the meter down, avoiding the

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F 441	Continued From page 32 battery compartment, code ship port, and the test strip port. c. Allow the Blood Glucose Meter (glucometer) to completely dry (according to manufacturer's directions to mitigate HIV [minimize the risk of Human Immunodeficiency Virus], other viruses and bacteria) before doing the next blood glucose check." A 1/27/15, Medication Administration: General Guidelines policy noted, "If breaking tablets is necessary to administer the proper dose, hands must be washed with soap and water or alcohol based hand sanitizer, and gloves used prior to handling tablets."	F 441		

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

F5520024

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FORM APPROVED
OMB NO. 0938-0391

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on October 20, 2015. At the time of this survey, Redeemer Residence was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/14/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING **01 - BUILDING 01** B. WING _____	**10/20/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Redeemer Residence is a 3-story building with a full basement. The building was constructed at 3 different times. The original 3 story building was constructed in 1960 and was determined to be of Type II(222) construction. In 1975, a 3 story addition was constructed to the South that was determined to be of Type II(222) construction. In 1995, a 3 story addition was constructed to the East that was determined to be of Type II(222) construction. Because the original building and the 2 additions are of the same type of construction, the facility was surveyed as one building. This building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 129 beds and had a census of 114 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 025	Continued From page 2	K 025		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide smoke barrier walls construction that meets the requirements of NFPA 101 - 2000 edition, Sections 19.3.7.3 and 8.3. This deficient practice could affect 30 residents. Findings include: On facility tour between 11:30 AM and 3:30 PM on 10/20/2015, it was observed that the 3 East Wing smoke barrier wall had penentrations around conduits that were not properly sealed with fire rated material not in accordance with 19.3.7.3. This deficient practice was confirmed by the Maintenance Supervisor.	K 025	The penetration described in this observation has been properly caulked with fire rated material according to NFPA standards. Responsible person: Director on Maintenance	10/21/15
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		11/24/15

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REDEEMER RESIDENCE INC	**625 WEST 31ST STREET** **MINNEAPOLIS, MN 55408**

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K 050	Continued From page 3 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of records and staff interview, it was determined that the facility failed to vary the times in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 114 residents. Findings include: On facility tour between 11:30 AM and 3:30 PM on 10/20/2015, a review of the available fire drill reports in 2014 and 2015 revealed that the facility has two shifts and conducted fire drills between the hours of 4:00 AM-8:00 PM, however no fire drills were conducted after the hours of 8:00 PM-4:00 AM not varying the times in accordance with Section 19.7.1.2. This deficient practice was confirmed by the Maintenance Supervisor.	K 050	It is the practice of the facility that all staff are trained and familiar with the facility's fire procedures. The facility has two shifts of staff who participate in random unannounced fire drills on a monthly basis which exceeds the Fire/safety code requirements. Fire drills were not conducted during the time noted because the facility does not wish to disturb or excite residents during their sleeping hours. This practice is allowable within the code Also, based on our Synchronizers of Sundowners DHS PIPP grant, our goal is to provide the optimum sleeping environment for your residents. To correct this deficiency, a calendar of drills will be established that will vary fire drill times through-out the year. Compliance will be maintained through audits and presented to the Quality Assurance Committee. Responsible person: Maintenance	

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K 052	Continued From page 4	K 052		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility's fire alarm system is not maintained in conformance with NFPA 72, (99). This deficient practice could affect the 30 residents. Findings include: On facility tour between the hours of 11:30 AM and 3:30 PM on 10/20/2015, during fire alarm documentation review it was revealed that the pull station by Rm 231 could not be tested and needed to be replaced. This deficient practice was verified by the Maintenance Supervisor.	K 052	After conversation with the facility's fire service company, it was discovered that the service company's initial report was misrepresented, stating that the pull station could not be tested and was not operable. The service company has now tested the pull station tested and found it to be operable. Pull stations will be monitored and tested for operation and compliance to NFPA codes by the service company. Responsible person: Maintenance Director	10/23/15
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved,	K 054		1/17/16

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K 054	Continued From page 5 maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to maintain the fire alarm system in accordance with the requirement 1999 NFPA 72, Sections 7-3.2 and 7-3.2.1. Findings include: On facility tour between the hours of 11:30 AM and 3:30 PM on 10/20/2015, during fire alarm documentation review it was revealed that the south wing had 30 resident room hard-wired smoke detectors that were obsolete in accordance with NFPA 72(99). This finding was confirmed with the Maintenance Supervisor at the time of discovery.	K 054	It is the facility's practice to ensure that residents and staff are provided the utmost protection and safety within the building and around the grounds of the facility. According to federal regulations 483.70 smoke detectors are required with the exception that the building has a sprinkler system. The facility is totally covered by a fire safety system and has a fire sprinkler system in place through-out the building. The described addition was constructed according to Federal regulations. To comply with the Fire/Safety code the facility will contract with a service company to bring the building into compliance with the life-safety code. The facility is currently waiting to receive bids back from the contractors. A contractor will be selected and the project completed to meet code. Responsible person: Maintenance Director	

MDH
Minnesota
Department
of Health

Certified Mail # 7015 0640 0003 5695 5002

November 3, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5520026

Dear Mr. Colgan:

The above facility was surveyed on October 12, 2015 through October 15, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing 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.

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

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

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

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, PO Box 64900 St Paul Mn 55164-0900. 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, y**ou should immediately contact Gayle lantto at (651) 201-3794 or email: gayle.lantto@state.mn.us.**

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 if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00160	A. BUILDING: _____ B. WING _____	10/15/2015

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

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2 000	Initial Comments *****ATTENTION****** NH 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 delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 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 October 12th, 13th, 14th, 15th 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 Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or	2 265		11/24/15

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2 265	Continued From page 3 E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify a responsible party of a fall shortly after admission for 1 of 1 resident (R175) whose family member reported lack of notification. Findings include: R175's family member (FM)-A was interviewed on 10/12/15, at 1:40 p.m. FM-A reported R175 had experienced a fall on "Friday," however, she had only learned of the information when she came to visit "today" (Monday). She confirmed she was the responsible party for R175. R175's nurse's note revealed the resident had been admitted on 10/9/15 at 7:11 p.m. looking "frail and cachectic [in ill-health]." She was instructed to use the call light if she needed help, and the bed was in the lowest position. A fall report also dated 10/9/15, at 7:38 p.m. revealed R175 was "found prone [face down] on the floor at around 1845 [6:45 p.m.], stated, 'I don't know what happened, I fell.' Resident showed some confusion and no agitation. No injuries, bleeding, contusion, abrasion or hematoma [bruising, scrapes, or swelling filled with blood] noted on head. Assisted to bed, will be monitored throughout the night." A registered nurse (RN)-D was interviewed on 10/14/15, at 3:26 p.m. RN-D reported RN-E was on duty and had notified the family of R175's fall on 10/9/15, at 8:20 p.m.	2 265	Corrected	

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2 265	Continued From page 4 A Safety Events form dated 10/09/15 indicated RN-E notified R175's family at "2030" (8:30 p.m.). A follow up telephone call was placed to FM-A on 10/15/15, at 10:23 a.m. FM-A reported she arrived at the facility to visit R175 on 10/12/15, at approximately 10:30 a.m. During her visit her told her she had experienced a fall. She then inquired with the nurse who was working that day, who verified her mother indeed had fallen on 10/9/15. When told it was documented a nurse called her the day of the fall she emphatically replied, "That's a lie," and said no message had been left on either her home or cell phone. In a follow up interview with RN-D at 10:30 a.m. he stated he had contacted RN-E who documented family notification the fall. The nurse verified he had not actually contacted R175's family. RN-D thought the nurse probably intended to contact R175's family, but then forgot. RN-D, the nurse manager of the unit, stated he expected family to be called regarding all falls. The facility's 9/11, Fall Management Policy--Protocol for Investigation of a Fall directed licensed nurses to contact family member/designated person. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revise policies and procedures as needed. Staff could be trained. Audits could be conducted to ensure responsible parties are notified of changes in a resident's health status, and the results of the audits could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen	2 265		

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2 265	Continued From page 5 (14) days.	2 265		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a care plan was developed for 1 of 3 residents (R59) reviewed for activities of daily living. Findings include: R59's care plan lacked direction to staff as to how to ensure the resident was kept clean and odor free. The plan lacked identification of her dependence on staff for personal hygiene and bathing. An incontinence care plan noted the resident was at risk for incontinence. R59 was observed in her room on 10/12/15, at 1:30 p.m. Her was appeared greasy and was	2 555	Corrected	11/24/15

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2 555	Continued From page 6	2 555		

uncombed. A strong smell of urine was detected in the room. On 10/13,14, at 12:30 p.m. and 5:30 p.m. there was no change in the resident's appearance and a urine odor was present.

On 10/14/13, at 8:30 a.m. during an interview R59, she stated the staff helped her with her incontinent issues to change and clean up, as well as with weekly showering and washing her face each day. She was satisfied with her bathing routine. The resident again had greasy/uncombed hair and smelled of urine. The following day at 8:45 a.m. the resident's hair was still unclean and uncombed and a urine odor was noted. At that time the resident reported she did not know when her scheduled bath day.

R59's quarterly Minimum Data Set (MDS) revealed the resident was cognitively intact, and required extensive assistance with dressing, toilet use, and personal hygiene. She was noted as always incontinent of urine. The bathing portion of the assessment read, "Activity itself did not occur during the entire period." The resident did not resist care during the assessment period.

On 10/15/15, at 9:30 a.m. a registered nurse (RN)-B reviewed the care plan and verified ADLs was not included in the plan, but should have been.

A related policy was requested, but was not provided.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care plans are developed to ensure appropriate care of residents. The Director of Nursing or designee could educate all

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2 555	Continued From page 7 appropriate staff on the policies and procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided	2 840		11/24/15

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2 840	Continued From page 8 promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide hygiene services to ensure incontinent residents were odor free for 1 of 3 residents (R59) who were dependent on staff and were reviewed for activities of daily living (ADLs). Findings include: R59 was observed in her room on 10/12/15, at 1:30 p.m. A strong smell of urine was detected in the room. On 10/13,14, at 12:30 p.m. and 5:30 p.m. a urine odor was present. On 10/14/15, at 8:30 a.m. during an interview R59, she stated the staff helped her with her incontinent issues to change and clean up. She was satisfied with her bathing routine. The resident again smelled of urine. The following day at 8:45 a.m. a urine odor was noted. R59's quarterly Minimum Data Set (MDS) revealed the resident was cognitively intact, and required extensive assistance bathing and toilet	2 840	Corrected	

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2 840	Continued From page 9 use. She was noted as always incontinent of urine. The resident did not resist care. The care plan for R59 lacked direction to staff as to how to ensure the resident was kept odor free. An incontinence care plan noted the resident was at risk for incontinence. On 10/15/15, at 9:30 a.m. a registered nurse (RN)-B reported she was unaware R59 smelled of urine. She said the staff was responsible for ensuring R59 was assisted with incontinence care and to maintain good hygiene. A related policy was requested, but was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to ensure dignified care and services are provided to residents who do not have the ability to do their own ADL care independently. Employees could be re-educated on these policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 840		
2 845	MN Rule 4658.0520 Subp. 2 C Adequate and Proper Nursing Care; Shampoo Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include:	2 845		11/24/15

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2 845	Continued From page 10 C. A shampoo at least weekly and assistance with daily hair grooming as needed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide hygiene services to ensure residents hair was clean and combed for 1 of 3 residents (R59) who were dependent on staff and were reviewed for activities of daily living (ADLs). Findings include: R59 was observed in her room on 10/12/15, at 1:30 p.m. Her was appeared greasy and was uncombed. On 10/13,14, at 12:30 p.m. and 5:30 p.m. there was no change in the resident's appearance. On 10/14/13, at 8:30 a.m. during an interview R59, she stated the staff helped her with her with weekly showering and washing her face each day. She was satisfied with her bathing routine. The resident again had greasy/uncombed hair. The following day at 8:45 a.m. the resident's hair was still unclean and uncombed. At that time the resident reported she did not know when her scheduled bath day. R59's quarterly Minimum Data Set (MDS) revealed the resident was cognitively intact, and required extensive assistance with personal hygiene. The bathing portion of the assessment read, "Activity itself did not occur during the entire period." The resident did not resist care. The care plan for R59 lacked direction to staff as to how to ensure the resident was kept clean and odor free. The plan lacked identification of her	2 845	Corrected	

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2 845	Continued From page 11 dependence on staff for personal hygiene and bathing. On 10/15/15, at 9:30 a.m. a registered nurse (RN)-B reported she was unaware R59 her hair was unclean and uncombed. She said the staff was responsible for ensuring R59 was assisted with to maintain good hygiene. A related policy was requested, but was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to ensure dignified care and services are provided to residents who do not have the ability to do their own ADL care independently. Employees could be re-educated on these policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 845		
2 960	MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 960	Corrected	11/24/15

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2 960	Continued From page 12 review the facility failed to ensure food was served at palatable temperatures for 1 of 1 resident (R160) who requested food reheated and potentially the other 14 residents in the 2W dining room. Findings include: Noon meal observations were conducted on 10/12/15, at 12:00 p.m. in the 2W dining room. A dietary aide (DA)-A entered the dining room with two metal food warmers that had food containers covered with foil, but no metal covers. DA-A then plugged in the food warmers, and instead of partially leaving the food covered to ensure maximum temperatures were maintained, the foil covers were removed. Temperatures were then taken of the individual foods. When taking the temperatures, however, a click was heard as the metal probe touched the bottom of the pan. DA-A stated it was the way he usually measured food temperatures with the probe on the bottom of the pan. The corn registered 120 degrees Fahrenheit (F), and chicken noodle and tomato soup registered 140 degrees. DA-A reported the hot foods should have registered 160 degrees, and if they did not he heated foods when residents asked for food to be re-heated. At 12:19 p.m. R160 stood up and took her plate of food from the table to the microwave in the room to re-heat her food. A discussion then took place between DA-A and a nursing assistant as to how long the food needed to be microwaved. A staff person then assisted the resident to reheat the plate of food. R160 explained to the surveyor, "My meat was not warm." The surveyor asked DA-A to measure the temperature of the R160's pork rib and it registered 120 degrees after being heated in the microwave for one minute. DA-A	2 960		

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2 960	Continued From page 13	2 960		

then proceeded to reheat R160's pork riblets, potatoes, and mixed vegetables a second time in the microwave for two minutes before reserving to R160. A second pan of pork riblets covered with foil was hand carried up from the kitchen. The riblets registered 130 degrees, and DA-A proceeded to individually microwave each plate served of riblets, potatoes and mixed vegetables or corn to the rest of the residents who had not yet been served in the dining room. The food in the warmers was left uncovered throughout the dining service. At 12:25 p.m. mashed potatoes in the food warmers registered 120 degrees and mixed vegetables registered 130 degrees when temperatures were re-taken. Five minutes later the dining director (DD) reported that the second pan of pork riblets sent to replace the first pan left the kitchen at 170 degrees. The surveyor then informed the DD that the riblets measured 130 degrees after arrival when DA-A measured it. DD stated she did not know whether the riblets had been immediately delivered, or whether there was a delay due to the elevators being busy. She said an announcement had been made over the loudspeaker to keep the elevators free during mealtime.

The following day at 11:41 a.m. R160 reported, "My food is frequently cool--not hot enough. I heat my food up in the microwave quite often...So I guess it is something you have to put up with and do your self." R160 stated she usually was served "right away" and said she was glad the surveyor was present to see the food was not being served hot enough.

At the noon meal at 12:06 p.m. DA-C brought up a food cart with two metal warmers placed on the top with foil coverings. DA-C then plugged in the warmer and proceeded to measure the

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2 960	Continued From page 14 temperatures of the food. A click was again heard as the probe touched the bottom of the metal pan when the meatloaf temperature was measured. DA-C pulled the foil back from the individual pans and did not partially or re-cover the food. Hamburger registered 120 degrees, chicken legs registered 123 degrees and chicken noodle soup registered 140 degrees. The surveyor reviewed the temperatures after DA-C had recorded the temperatures on a log. The temperatures, however, were written on different columns different from that foods' column. When asked why the temperatures were recorded as they were, DA-C replied, "I sometimes write the temperature anywhere as there is no place for it on the log." DA-C also stated only 2W and 3W dining rooms used warmers to transport and serve the food, as the other dining rooms had kitchenettes. When asked about the hamburger and chicken legs temperatures being lower than the policy directed, DA-C explained that she would have warmed the food per resident request. At 12:32 p.m. DD stated, "Since we talked yesterday, I re-told the staff in morning meeting today to put plastic covers on the warmers" during transport, and to keep the food covered during the meal service. She was unsure why when all staff had been trained, that the covers were not in use in the 2W dining room, but she would continue to monitor the situation. The change from steam tables in the two dining areas to the use of the warmers had started just a year ago, and they had not maintained the Cayenne Vollrath (brand name) manufacturer's instructions. On 10/14/15, at 8:41 a.m. plastic covers were utilized to cover foods at the breakfast meal.	2 960		

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2 960	Continued From page 15 DA-B stated she always used the plastic covers on the warmers, but that dietary staff "work differently" with some dietary staff just covering the food with foil. DA-B also reported she had been taught by the DD to utilize the plastic covers. In addition, they were supposed to ensure the metal probe touched the bottom of the metal pan when taking temperatures, to ensure the entire food was warm. DA-B was unsure whether measuring the metal probe touching the bottom of the pan would potentially erroneously affect the temperature of the food. At the noon meal that same day at 12:01 p.m. in the 2W dining room, food warmers were observed being transported with the plastic covers off the pans as much as four to five inches, as there were multiple different shaped pans stacked, thus preventing the covers from fitting snuggly. Three of the eight pans were stacked on lower pans and were not in contact with the hot water intended to keep the food hot. DA-B plugged in the warmers and measured food temperatures. Chicken soup registered 112 degrees and tomato soup registered 118 degrees. When asked about the temperatures DA-B stated, "110 degrees is okay for soup." After the meal DD stated she had trained staff to touch the bottom of the pan with the probe. DD verified the metal pans should have all been directly in contact with the hot water in the warmer. Policies regarding food temperatures and serving was requested but not provided by the facility. SUGGESTED METHOD OF CORRECTION: The dietitian and food service director could ensure policies and procedures are accurateand address food palatability including food served at	2 960		

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2 960	Continued From page 16 the proper temperatures. Appropriate staff could be trained. Audits of food temperatures could be conducted and residents randomly interviewed for satisfaction. The results of the audits could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 960		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure infection control procedures were followed to minimize the risk for spread of infection for 1 of 1 resident (R57) observed blood glucose test and additionally affecting a second resident for whom the device was also utilized. In addition, medication was not administered in a sanitary manner for 1 of of 5 residents (R66) whose medication administration was observed. Findings include: R57's blood sugar was checked on 10/14/15, at 11:56 a.m. by a registered nurse (RN)-A. After the check was completed, RN-A used a Sani Wipe germicidal cloth to clean the glucometer for 3-4 seconds, and then set the glucometer on top of the medication cart. RN-A was asked if this	21375	Corrected	11/24/15

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21375	Continued From page 17	21375		

was the usual manner for cleaning glucometers. RN-A said it was her usual practice to wipe the glucometer for five seconds before and after use. RN-A also reported the glucometer was used at the current time by two residents. The facility had recently "audited" her on this, and stated it was how she cleaned the glucometer during the auditing process.

At 1:05 p.m. a licensed practical nurse (LPN)-B reported she wiped the entire glucometer all over with the Sani Wipe, and then wrapped the Sani Wipe around the glucometer for three seconds. The surveyor then clarified with LPN-B if she indeed meant three seconds and LPN-B again stated, "three seconds."

Thirty minutes later, RN-B explained nurses were to clean glucometers after each use "according to the manufacturer's instructions." RN-B then referred to the instructions on the Sani Wipe container and read, "two minutes." RN-B said glucometers should have remained wet by wrapping the wipe around the glucometer and leaving it for two minutes.

At 1:58 p.m. RN-C reported being recently hired at the facility. She stated glucometers should be wiped "real good" and left to air dry. RN-C was unsure how long the glucometer should be wiped or stay wet, and how long it needed to be air dried prior to use on another resident.

R66's calcium/vitamin D3 tablet was administered by RN-A on 10/14/15, at 8:35 a.m. Without washing her hands or using alcohol gel, RN-A cut the tablet with her bare hands. RN-A said it was the usual method she used to break the tablets, and she was unsure how to break the medication in half without touching it. The rationale for

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21375	Continued From page 18 breaking the tablet was that it was "easier" for R66 to swallow. Following the observation, the director of nursing (DON) was interviewed, and said nurses should have followed manufacture's instructions for sanitizing the glucometers, and verified related audits to ensure compliance had been conducted with nurses. The DON further explained it was expected a nurse would not touch a resident's medication with their hands. A 3/19/12, Blood Glucose Meter Disinfection policy directed staff as follows: "Purpose: To maintain cleanliness of blood glucose meter (glucometer) and prevent cross-contamination with blood-borne pathogens between each resident use...Disinfect the blood glucose meter: a. Remove the EPA [Environmental Protection Agency] approved disinfectant wipe from container. b. Wipe the meter down, avoiding the battery compartment, code ship port, and the test strip port. c. Allow the Blood Glucose Meter (glucometer) to completely dry (according to manufacturer's directions to mitigate HIV [minimize the risk of Human Immunodeficiency Virus], other viruses and bacteria) before doing the next blood glucose check." A 1/27/15, Medication Administration: General Guidelines policy noted, "If breaking tablets is necessary to administer the proper dose, hands must be washed with soap and water or alcohol based hand sanitizer, and gloves used prior to handling tablets." SUGGESTED METHOD OF CORRECTION: The director of nursing and infection control nurse could ensure policies and procedures are accurate and licensed nurses could be trained.	21375		

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21375	Continued From page 19 Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure self-administration of medications was a safe practice for 1 of 1 resident (R132) observed with medications left at the bedside. Findings include: R132 was observed on 10/15/15, at 1:29 p.m. while sitting in a recliner in her room. The resident was whimpering. A medicine cup containing five pills was on the footrest in front of her, and another pill was outside the cup on the footrest. R132 verified the pills were hers, and that she was in pain. The surveyor immediately summoned the director of nursing (DON) and a registered nurse. RN-D verified R132 was only allowed to self-administer topical medications. RN-D then discovered R132 had declined taking the medications, but said the	21565	Corrected	11/24/15

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21565	Continued From page 20 nurse should not have left R132 with the medications. The Self-Administration of Medication assessment for R132 dated 5/5/15, revealed the resident was capable of administering a topical medication that was left in her room for self-administration. R132's care plan dated 5/5/15, indicated a Self-Administration of Medication assessment was to be completed prior to allowing the resident to self-administrate medications. The care plan noted R132 could, however, self-administer the topical medication. A 1/13, Medication-Self Administration policy indicated "All medications must be administered by facility staff until their ability to self administer has been assessed. Staff must obtain an order from the physician for a resident to self administer and the care plan is to be updated." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or desigee could ensure all residents who wish to self-administer medications are assessed and deemed safe to do so. Staff responsible could be trained. Audits could be conducted to ensure compliance and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21565		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common	21990		11/24/15

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	00160	A. BUILDING: _____ B. WING _____	10/15/2015

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21990	Continued From page 21 entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the administrator and designated State agency (SA) and to thoroughly investigate an allegation for 1 of 2 residents (R174, R48) who alleged verbal abuse by a staff person. Findings include: R174 reported he was not treated with dignity and respect by a nursing assistant (NA), during an interview on 10/13/15, at 3:03 p.m. The resident physically described the NA. He stated the incident happened the morning of 10/11/15 during morning cares. The resident said the NA had a "poor attitude...When she was changing my diapers she made a comment to demean me, 'What is all that white stuff coming out?'" When the resident coughed she told him to "Put your hand across your mouth!" She then turned the	21990	Corrected	

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21990	Continued From page 22	21990		

the other nursing assistant (NA)-A and stated she had told him to cover his mouth before and added, "He probably has TB [tuberculosis]. He should be checked for that." R174 said the NA had made other demeaning remarks in the past and had been indifferent toward him. He stated he had not reported it to anyone, but it "made me feel small...I didn't reply, because I realize you cannot talk to ignorance like that."

During a second conversation on 10/14/15, at 12:50 p.m. R174 stated he reported the incident to the social worker earlier that day because he felt he had been abused verbally by NA-A.

An interview with a licensed social worker (LSW) on 10/15/15, at 8:16 a.m., revealed R174 had told her first on 10/12/15 regarding the incident during their initial visit. The LSW stated R174 did not like the way the NA-A made him feel but did not consider this to be abuse. She further explained R174 spoke to her again on 10/14/15 regarding his treatment and this time stated he felt he was verbally abused by NA-A. The LSW stated she brought it to the attention of the corporate representative and was told it was not a reportable incident. An investigation was not initiated at this time.

At 8:33 a.m. the same day another NA was interviewed. NA-B stated on 10/12/15, during morning rounds NA-A asked for assistance with providing care for R174. While they were assisting R174 , NA-A removed his incontinent brief and asked the resident, "What is all that yucky white stuff in there [incontinent brief]?" NA-B explained is was the cream they had applied to his skin for protection. NA-A then stated "He was so bad this morning, he was like an asshole" (because he was anxious and kept

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turning on his light). She added NA-A had made these statements in the presence of the resident, and portrayed this type of demeanor often. NA-B stated she had reported the situation to RN-F.

At 8:49 a.m. R174 stated when he first reported the abuse on Monday he did not consider it as abuse but later he did. He reported it to the LSW as abuse and stated it made him "feel insignificant."

At 8:59 a.m. while explaining the incident the director of nursing (DON) she verified the LSW was reporting at that time. She further explained she would have expected an incident of reported abuse to be reported to the SA immediately. "This should have been reported yesterday. It is our policy."

At approximately 9:32 a.m., RN-D explained RN-F was not in the facility but spoke to her by phone. She did not recall NA-B reporting the incident.

Later that day at 10:02 a.m. the DON stated she spoke with the corporate representative and verified the LSW had brought the allegation to her attention, but did not feel it was a reportable incident.

R174 was newly admitted to the facility with diagnoses including anxiety. A Brief interview for Mental Status score dated 10/12/15, revealed intact cognition (15/15 possible).

Nursing progress notes were reviewed but lacked mention of this incident.

A request for all incident reports for R174 was requested but was not provided.

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21990	Continued From page 24 R48's incident report was submitted to the SA on 8/26/15, which revealed NA-Y reported NA-Z swore at the resident during evening cares on 8/25/15. R48 could not recall the event. A documented interview in the investigative file dated 8/26/15, revealed NA-Y did not report the incident to a supervisor until the following day. The investigative report was not submitted to the SA until 8/31/15, and lacked interviews of appropriate persons to determine their potential knowledge of the incident or similar allegations. The report did not include a rationale as to why the report was not made by NA-Y until the following day, nor measures taken to ensure NA-Y reported immediately in the future. R48's Minimum Data Set (MDS) dated 8/12/15, revealed the resident had short and long term memory problems and required staff extensive staff assistance for cares such as bed mobility, personal hygiene, dressing, toileting, and transferring. On 10/15/15, at 12:27 p.m. the director of nursing (DON) reported NA-Y may have delayed reporting because the incident did not occur until the end of her shift. The DON reported she would have expected allegations to be immediately reported. Although she had spoken to NA-Y about immediate reporting, she had not documented the conversation. The DON explained a previous manager had completed the investigation into R48's allegation, and believed appropriate persons had been interviewed, but again, had not been documented. The DON verified other residents or their family members and staff persons should have been interviewed about their knowledge of how residents were	21990		

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being treated and/or their knowledge of potential similar allegations. The DON reported she would review NA-Y's employee file regarding immediate reporting of allegations and check to see if any other investigative information was available related to R48.

The facility's 9/13, Vulnerable Adult Abuse Prohibition Plan directed staff: "Each employee is responsible to report suspected/alleged violations of mistreatment, neglect, and abuse of residents and/or misappropriation of resident property immediately to one of the following: Nursing Supervisor, Nurse on Duty, Director of Nursing or Social Worker. The administrator will be notified immediately by one of the above. Staff may go immediately to the Administrator if desired. Report all alleged violations and substantiated incidents immediately to the SA and all other agencies as required...Identify events, such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse and determine the direction of the investigation...1. All reports of suspected/alleged resident abuse, neglect, mistreatment, injuries of unknown source and/or misappropriation of resident property shall be promptly and thoroughly investigated. 2. Collect data and document investigative findings. 3. The investigation may include but is not limited to: physical examination of the resident and environment. Examination of the resident by a licensed nurse or physician. IF sexual abuse is suspected, call the police immediately. DO NOT bathe/wash the resident or wash the resident's clothing or linen. Do not take items from the area in which the incident occurred. Review documentation and the resident's medial record for events leading up to incident. Interview the person(s) reporting the incident. Interview the

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21990	Continued From page 26 alleged victim. Interview any potential witness to the incident. Interview the alleged perpetrator. Interview other residents to whom the alleged perpetrator provides care or services. Review the completed documentation." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review, revise, develop and implement policies and procedures to ensure allegations of abuse are reported immediately. In addition random audits could be conducted and staff training provided to ensure all allegations are investigated and reported correctly. Audits could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21990		