DEPARTMENT OF HEALTI	H AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: J1L7
	PART I -	TO BE COMPI	LETED BY T	THE STA	TE SURVEY AGENCY	Facility ID: 00160
1. MEDICARE/MEDICAID PROVIDE (L1) 245520	ER NO.	3. NAME AND AL (L3) REDEEMED				4. TYPE OF ACTION: <u>7 (</u> L8) 1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID N	1O.	(L4) 625 WEST 3	1ST STREET			3. Termination 4. CHOW
(L2) 599340700		(L5) MINNEAPO	DLIS, MN		(L6) 55408	5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEO 05 HHA	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 12/21	/ 2015 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FIGURE VEAD ENDING DATE (122)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/II		FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
11LTC PERIOD OF CERTIFICATION	Ň	10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		X A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b) :			equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
12. Total Facility Beds	129 (L18)	1	cceptable POC		4. 7-Day RN (Rural SN	
					5. Life Safety Code	9. Beds/Room
13.Total Certified Beds	129 (L17)		pliance with Progents and/or Appli		: * Code: A	(L12)
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS	
18 SNF 18/19 SNF 129	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM.	ARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION	DATE):		
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Shawn Soucek, HPR	SW	0	1/14/2016	(L19)	Mark Meath	, Enforcement Specialist 01/14/2016 (L20)
PAI	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONA	L OFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF ELIGIBIL	ITY	20. COM	PLIANCE WITH	H CIVIL	21. 1. Statement of Finar	ncial Solvency (HCFA-2572)
X 1. Facility is Eligible to P	articipate	RIGH	ITS ACT:		 Ownership/Control Both of the Above 	ol Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	-				5. Dour of the ricove	
	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNINC	J DATE	ENDING DA	TE	<u>VOLUNTARY</u> <u>00</u>	
02/01/1988					01-Merger, Closure 02-Dissatisfaction W/ Reimburse	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		03-Risk of Involuntary Terminatio	nn
25. LTC EXTENSION DATE:	27. ALTERNATI				04-Other Reason for Withdrawal	07-Provider Status Change
	A. Suspension	n of Admissions:	(L44)			00-Active
(L27)	B. Rescind St	uspension Date:	()			
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	21	2. DETERMINATION		DATE		
51. KO KECEIF I OF UM5-1559	32	12/01/2015	JI ALL KUVAL	DALE		
	(L32)			(L33)	DETERMINATION APPI	ROVAL

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.



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



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

Redeemer Residence Inc January 14, 2016 Page 2

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

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245520	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
		Correction			Correction			Correction
ID Prefix	F0431	Completed 12/21/2015	ID Prefix		Completed	ID Prefix		Completed
Rea. #	483.60(b), (d), (e)	_				Reg. #		
LSC		_	LSC					
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #		_	Reg. #					
LSC		-				LSC		
		0 //			a "			0 //
		Correction Completed			Correction Completed			Correction Completed
ID Prefix			ID Prefix		Completed	ID Prefix		
Reg. #			Reg. #			Reg. #		
LSC						LSC		
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		-	ID Prefix			ID Prefix		
Reg. #		_	Reg. #			Reg. #		
LSC		_	LSC			LSC _		
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		_	ID Prefix			ID Prefix		
Reg. # LSC						Reg. #		
		_						
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	yor:		Date:	
State Agency	GL/m	m	01/12/2016			30923	12/2	21/2015
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	yor:		Date:	
CMS RO								
Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of						
	10/15/2015			Uncorrecte	d Deficiencies	6 (CMS-2567) Sent to	o the Facility? YES	NO

Post-Certification Revisit Report

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

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

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	Followup to Survey Completed on:				Check for any Uncorrected Deficiencies. Was a Summarv of									
		10/20)/2015					-				-	YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

			AND TRANSMITTAL ID: J1L7 XTE SURVEY AGENCY Facility ID: 00160						
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245520 2.STATE VENDOR OR MEDICAID NO. (L2) 599340700).	 NAME AND ADD (L3) REDEEMER (L4) 625 WEST 31 (L5) MINNEAPO 	RESIDENCE IN		(L6) 55408	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation 7. On-Site Visit	<u>7 (</u> L8) 2. Recertification 4. CHOW 6. Complaint 9. Other		
5. EFFECTIVE DATE CHANGE OF OWN (L9)	ERSHIP	7. PROVIDER/SUI 01 Hospital	PPLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Co			
6. DATE OF SURVEY 11/24/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING 12/31	DATE: (L35)		
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 129 (L37) (L38) 16. STATE SURVEY AGENCY REMARK See Attached Remarks	129 (L18) 129 (L17) 19 SNF (L39) S (IF APPLICABLE S	X B. Not in Com Requirement ICF (L42)	the With equirements e Based On: ecceptable POC pliance with Program ents and/or Applied V IID (L43)		And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: B* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Servic 7. Medical Direct	or		
See Attached Remarks 17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AP	PDOVAL	Date:		
<u>Conrad Simba, HFE N</u>	IEII		12/02/2015	(L19)	Mart meeth, Enforcement Specialist 01/08/2016				
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAI	OFFICE OR SINGLE STAT	TE AGENCY			
 DETERMINATION OF ELIGIBILITY _X1. Facility is Eligible to Particular 2. Facility is not Eligible 	cipate (L21)		IPLIANCE WITH CI ITS ACT:	IVIL	 Statement of Financ Ownership/Control I Both of the Above : 	ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA	-1513)		
22. ORIGINAL DATE OF PARTICIPATION 02/01/1988	23. LTC AGREEM		24. LTC AGREEME ENDING DATE		26. TERMINATION ACTION: <u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure	INVOLUNT 05-Fail to Me	eet Health/Safety		
(L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATIVE A. Suspension of		(L25) (L44)		02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	<u>OTHER</u>	eet Agreement Status Change		
(L27)	B. Rescind Susp	pension Date:							
28. TERMINATION DATE:	29.	INTERMEDIARY/C	(L45) ARRIER NO.		30. REMARKS				
		03001							
	(L28)	-		(L31)					
31. RO RECEIPT OF CMS-1539	32.	DETERMINATION (12/01/2015	OF APPROVAL DAT	Έ					
	(L32)			(L33)	DETERMINATION APPRO	VAL			

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY ID: J1L7 Facility ID: 00160

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.



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 <u>https://dab.efile.hhs.gov</u> 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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			COM	E SURVEY IPLETED
		245520	B. WING				R 25/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	11/1	23/2013
REDEEM	IER RESIDENCE INC				25 WEST 31ST STREET IINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENT	rs	{F 00	00}			
{F 431} SS=D	completed on Nove certification tags that found on the CMS 2 uncorrected deficie which can be found Because you are en- signature is not req page of the CMS-2 submission of the F verification of comp Upon receipt of an on-site revisit of you validate that substa- regulations has bee your verification. 483.60(b), (d), (e) D LABEL/STORE DR The facility must en a licensed pharmac of records of receip controlled drugs in accurate reconciliat reconciled. Drugs and biologica labeled in accordar professional princip appropriate access	nrolled in ePOC, your uired at the bottom of the first 567 form. Your electronic POC will be used as bliance. acceptable electronic POC, an ur facility will be conducted to antial compliance with the en attained in accordance with DRUG RECORDS, UGS & BIOLOGICALS nploy or obtain the services of cist who establishes a system at and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be nee with currently accepted bles, and include the	{F 43	31}			12/14/15
		DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	_	TITLE		(X6) DATE
Electron	ically 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.

PRINTED: 01/08/2016

		AND HUMAN SERVICES			F	ORM	01/08/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION (X:	COMF	E SURVEY PLETED
		245520	B. WING	i		F 11/2	1 25/2015
NAME OF I	PROVIDER OR SUPPLIER	L		5	STREET ADDRESS, CITY, STATE, ZIP CODE		.0/2010
PEDEEM	IER RESIDENCE INC			6	625 WEST 31ST STREET		
NEDEEN				I	MINNEAPOLIS, MN 55408		
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{F 431}	In accordance with facility must store a locked compartmen controls, and permi have access to the The facility must pr permanently affixed controlled drugs list Comprehensive Dr Control Act of 1976 abuse, except when package drug distri	State and Federal laws, the III drugs and biologicals in its under proper temperature t only authorized personnel to keys. ovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the inimal and a missing dose can	F 4	31}			
	by: Based on observative review, the facility for were securely store minimize the risk of potential drug diver affect 24 residents unauthorized staff of Findings include: On 11/24/15, at 11: waiting to observe to 3 east unit, three recursive unattended medica area, however, the with several resider registered nurse (R and reported the lice)	NT is not met as evidenced tion, interview and document ailed to ensure medications ed in 1 of 6 medication carts to f unintentional ingestion and/or sion. This has the potential to on the unit, as well as or visitors. 18 a.m. as the surveyor was the medication storage on the esidents passed by an the tion cart. No nurse was in the pastor was visiting in the area ents. A short time later a N)-A came toward the area ensed practical nurse (LPN)-A e unit, but probably was on a			It is the practice of the facility to store medications and biologicals in locked compartments under proper temperat controls. In addition, to assign medic access keys and to permit only autho personnel to have access to medicati carts and med storage rooms. LPN-A had inadvertently left his med unattended to assist with a resident a upon his return was immediately re-educated on the proper procedures securing the med cart and medication storage on 11/24/2015. Nurses and TMAs were re-educated on facility po for medication storage. Random medication storage audits will be completed at least weekly. Audit resu reviewed by the QA team to determine	l ture cation rized ion cart und s of n blicy	

Facility ID: 00160

If continuation sheet Page 2 of 4

PRINTED: 01/08/2016 FORM APPROVED

TATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		SURVEY PLETED
		245520	B. WING _		F 11/2	{ 25/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
REDEEN	IER RESIDENCE INC			625 WEST 31ST STREET MINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
{F 431}	break. RN-A and the ring of keys and a co on top of the unatter nurse should not have medication cart and the area. RN-A veri- erythromycin (antib- were to unlock the residents' medication medications were so into the lock and tu cart, and then over the unit. Within a mand then returned as LPN-A explained have in the shower on the been off the unit the left the medication medications and the when he left the unit beca- for help, as R34 was LPN-B was then in stated she received wanted to speak to switching his bath of she gave R34 the p- unit, she saw LPN-the elevator. She the wanted to switch his A follow up interview said LPN-A was on LPN-B when she st	e surveyor both observed a cup containing two pills was left ended cart. RN-A explained the ave left the keys to the d medications when leaving fied the medication was iotic medication) and that keys medication cart were on, including controlled stored. RN-A placed the key rned the key, unlocking the head paged LPN-A to return to ninute LPN-A called the unit, a short time later. e had been helping a resident e 3 west hallway and had only ree minutes. LPN-A verified he cart unattended with e medication keys on top of it it. Later at 2:22 p.m. LPN-A d left the cart because of an n on 3 west. LPN-A explained ause LPN-B called him asking anted to change bath days. tterviewed at 2:26 p.m. LPN-B d a phone call from R34 who the nurse on 3 east about day. LPN-B said as soon as ohone number to the 3 east A coming from the direction of nen informed LPN-A R34	{F 43	31} frequency and duration of Responsible for complia Managers and Staff Edu Responsible for overall of Director of Nursing Completion date: 12/14/	nce: Nurse cation. compliance:	

If continuation sheet Page 3 of 4

		AND HUMAN SERVICES				FORM	01/08/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245520	B. WING				R 2 5/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
REDEEN	IER RESIDENCE INC			-	25 WEST 31ST STREET /INNEAPOLIS, MN 55408		
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{F 431}	had not been an en was unsure how lor medicaiton unatten had 24 residents re the 24 would have b keys to open the m The facility's plan o storage indicated a re-education related LPN-A and LPN-B a inservice on 11/4/15 The facility's 1/27/1 Facility policy indica and supplies are loo the consultant phar to medications. Ea	 hergency situation, and she ng LPN-A left the cart and ded. RN-A verified unit 3 east esiding on the unit, and 20 of been capable of using the edicaiton cart. f correction for medicaiton ppropriate staff would d to medication storage. Both attended the re-education 5. 5, Medication Storage In The ated "medication rooms, carts, cked and only licensed nurse, macist are allowed access ch nurse authorized to use the eart keys must carry these keys 	{F 4	31}			

Facility ID: 00160

If continuation sheet Page 4 of 4

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245520	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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	5)	Date	(Y4)	ltem		Y5) D	Date
			Correction				(Correction					Correction
ID Prefix	F0157		Completed 11/24/2015		ID Prefix	F0176		Completed 11/24/2015		ID Prefix	F0225		Completed 11/24/2015
	483.10(b)(11)					483.10(n)	_				483.13(c)(1)(ii)-(iii), (c)(2) -	- · (4)
LSC					LSC		_			LSC			-
			0					0 "					0 "
			Correction Completed					Correction Completed					Correction Completed
ID Prefix	F0226		11/24/2015		ID Prefix	F0279		11/24/2015		ID Prefix	F0312		11/24/2015
•	483.13(c)					483.20(d), 483.20(k)(1)				-	483.25(a)(3)		_
LSC					LSC		_			LSC			-
			Correction				(Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0364		11/24/2015		ID Prefix	F0441		11/24/2015		ID Prefix			_
-	483.35(d)(1)-(2)				-	483.65				Reg. #			_
LSC				<u> </u>	LSC					LSC			-
			Correction				(Correction					Correction
			Completed				(Completed					Completed
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					200		_		+	200			-
Reviewed By	/ Rev	viewed B	у	Dat	te:	Signature of Surv	/ey	vor:				Date:	
State Agency	, G	L/mm		1	11/30/2	015		355	574			11	/25/2015
Reviewed By	/ Rev	viewed B	у У	Dat	te:	Signature of Surv	/ey	vor:				Date:	
CMS RO													
Followup to	Survey Completed	on:					-				a Summary of		
	10/15/20	15				Uncorrect	ted	Deficiencies	(CM	S-2567) Sent	to the Facility?	YES	NO



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

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00160	B. WING		F 11/2	₹ 5/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
REDEEM	IER RESIDENCE INC		T 31ST STRE POLIS, MN 5			
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{2 000}	Initial Comments		{2 000}			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	Minnesota Departm on-site licensing rev orders issued as a completed on Octol orders were found i regulations.	FS: 2015, surveyors of the nent of Health completed an visit to follow up on licensing result of a licensing survey ber 15, 2015. All licensing in compliance with state				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

Electronically Signed

STATE FORM

6899

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	OF CONTLECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		00160	B. WING			R 25/2015
IAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
REDEEN	IER RESIDENCE INC		T 31ST STRE POLIS, MN 5			
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{2 000}	Continued From pa	age 1	{2 000}			
	signature is not rec page of state form. is required, it is req	lled in ePOC and therefore a quired at the bottom of the first Although no plan of correction puired that the facility pt of the electronic documents.				
innesota D	epartment of Health		699	111 740	f continu	

If continuation sheet 2 of 2

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00160	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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)	ltem	(Y5)	Date	(Y4)	ltem	(Y5)	Date
			Correction				Correction				Correction
			Completed				Completed				Completed
ID Prefix			11/24/2015		ID Prefix		11/24/2015			20840	11/24/2015
Reg. # LSC	MN Rule 4658	.0085	-		Reg. # LSC	MN Rule 4658.0405 Subp.	_1		Reg. # LSC	MN Rule 4658.0520 S	ubp. 2 B
			-		LSC		_		LSC		
			Correction				Correction				Correction
			Completed				Completed				Completed
ID Prefix	20845		11/24/2015		ID Prefix	20960	11/24/2015		ID Prefix	21375	11/24/2015
Reg. #	MN Rule 4658	.0520 Subp.	2 C		Reg. #	MN Rule 4658.0600 Subp.	1		Reg. #	MN Rule 4658.0800 S	ubp. 1
LSC			-		LSC		-		LSC		
			Correction				Correction				Correction
ID Prefix	21565		Completed 11/24/2015		ID Prefix	21990	Completed 11/24/2015		ID Prefix		Completed
		4225 Suba	_				_				
0	MN Rule 4658	-	4		•	MN St. Statute 626.557 Su	100.4		Reg. # LSC		
			-				-				
			Correction				Correction				Correction
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ID Prefix			-		ID Prefix		_		ID Prefix		
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LSC					LSC		_		LSC		
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			Correction Completed				Correction Completed				Correction Completed
ID Prefix			•		ID Prefix		•		ID Prefix		•
Reg. #			-		Reg. #				Reg. #		
LSC			-		LSC		_		LSC		
Reviewed By		Reviewed I	Ву	Da	ate:	Signature of Surve	eyor:			Date	:
State Agency	y	GL/mm		1	1/30/20	15	3	557	4	11	/25/2015
Reviewed By	,	Reviewed I	Ву	Da	ate:	Signature of Surv	eyor:			Date	:
CMS RO											
Followup to	Survey Compl	eted on:				Check for any	/ Uncorrected	Defici	encies. Was	a Summary of	
	10/15	5/2015								to the Facility? YES	S NO
STATE FORM	I: REVISIT REF	PORT (5	5/99)			Page 1 of 1				Event ID: J1L712	2

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION PART I - TO BE COMPLETED BY THE ST						ID: J1L7 Facility ID:	ID: J1L7 Facility ID: 00160		
1. MEDICARE/MEDICAID PROVIDER (L1) 245520 2.STATE VENDOR OR MEDICAID NO (L2) 599340700 5. EFFECTIVE DATE CHANGE OF OW		 NAME AND ADD (L3) REDEEMER (L4) 625 WEST 31 (L5) MINNEAPOI PROVIDER/SUP 	RESIDENCE IN ST STREET LIS, MN	С	(L6) 55408	3. Termination 4. CH0 5. Validation 6. Com 7. On-Site Visit 9. Other	ertification DW aplaint		
(L9) 6. DATE OF SURVEY 10/1 8. ACCREDITATION STATUS:	5/2015 (L34) (L10)	01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct	05 HHA 06 PRTF 07 X-Ray	09 ESRD 10 NF 11 ICF/III	13 PTIP 22 CLIA 14 CORF 0 15 ASC	8. Full Survey After Complaint FISCAL YEAR ENDING DATE:	(L35)		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31			
 LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWI 	129 (L18) 129 (L17)	X B. Not in Comp	ce With quirements	'aivers:	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: B * 15. FACILITY MEETS	6. Scope of Services Limit 7. Medical Director			
18 SNF 18/19 SNF		ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)			
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:			
17. SURVEYOR SIGNATURE		1	11/23/2015	(L19)	-Mark Enforcer	nent Specialist	1/30/2015 (L20)		
	PART II - TO	BE COMPLETEI 20. COM		GIONA	Enforcer LOFFICE OR SINGLE ST 21. 1. Statement of Fina	nent Specialist 11 ATE AGENCY Incial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)	/30/2015		
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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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 Redeemer Residence Inc November 3, 2015 Page 6 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: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		0	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	E SURVEY PLETED
		245520	B. WING		10/	15/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
REDEEM	ER RESIDENCE INC			625 WEST 31ST STREET MINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 000			
F 157 SS=D	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of you validate that substa regulations has beet your verification. 483.10(b)(11) NOT (INJURY/DECLINE A facility must immediate consult with the resist known, notify the resist or an interested fan accident involving the injury and has the printervention; a significantly (i.e., a existing form of treat consequences, or to treatment); or a dece the resident from the §483.12(a). The facility must als and, if known, the resist	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with	F 157			11/24/15
		ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
Electron	ically 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.

PRINTED: 11/23/2015

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			ОМ	FORM / IB NO.	11/23/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (2		E SURVEY PLETED
		245520	B. WING			10/1	5/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
REDEEM	IER RESIDENCE INC				25 WEST 31ST STREET IINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 157	change in room or r specified in §483.1 resident rights under regulations as spect this section. The facility must react the address and philegal representative This REQUIREMEN by: Based on interview facility failed to notif shortly after admiss whose family membrane notification. Findings include: R175's family membrane 10/12/15, at 1:40 p. experienced a fall of only learned of the invisit "today" (Mondar the responsible part R175's nurse's note been admitted on 1 "frail and cachectic instructed to use the and the bed was in A fall report also dar revealed R175 was the floor at around to don't know what hap	oommate assignment as 5(e)(2); or a change in r Federal or State law or ified in paragraph (b)(1) of cord and periodically update one number of the resident's or interested family member. IT is not met as evidenced and document review, the y a responsible party of a fall ion for 1 of 1 resident (R175) per reported lack of ber (FM)-A was interviewed on m. FM-A reported R175 had n "Friday," however, she had nformation when she came to ty). She confirmed she was ty for R175. e revealed the resident had 0/9/15 at 7:11 p.m. looking [in ill-health]." She was e call light if she needed help,	F 1	57	This response and plan of correction not admissions to or an agreement t deficiency exists or that the statement deficiency was correctly cited or fact based. It is the facility's practice to notify the residents ¿ primary contact with all fa- incidents. R175 primary contact was notified of fall on 10/12/2015. Nurse responsible contacting R175 family has been re-educated. Random Audits of fall incidents will be completed to ensure appropriate person has been contact Results will be reviewed by the QA te to determine duration and frequency audits. Responsible for compliance: Nurse Managers Responsible for overall compliance: Director of Nursing	hat a nt of a ually all f the le for e the ted. eam r of	

Facility ID: 00160

If continuation sheet Page 2 of 33

		AND HUMAN SERVICES				FORM	: 11/23/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245520	B. WING	·		10/	15/2015
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
REDEEM	IER RESIDENCE INC				325 WEST 31ST STREET MINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 157	injuries, bleeding, c hematoma [bruising with blood] noted of be monitored throug A registered nurse 10/14/15, at 3:26 p. on duty and had no on 10/9/15, at 3:26 p. on duty and had no on 10/9/15, at 3:20 A Safety Events for RN-E notified R175 A follow up telephon 10/15/15, at 10:23 a arrived at the facility approximately 10:3 her she had experie with the nurse who verified her mother When told it was do the day of the fall sl "That's a lie," and s on either her home In a follow up interv he stated he had co documented family verified he had not family. RN-D thoug intended to contact RN-D, the nurse ma expected family to R	contusion, abrasion or g, scrapes, or swelling filled n head. Assisted to bed, will ghout the night." (RN)-D was interviewed on .m. RN-D reported RN-E was tified the family of R175's fall p.m. m dated 10/09/15 indicated 5's family at "2030" (8:30 p.m.). ne call was placed to FM-A on a.m. FM-A reported she y to visit R175 on 10/12/15, at 0 a.m. During her visit her told enced a fall. She then inquired was working that day, who indeed had fallen on 10/9/15. Documented a nurse called her he emphatically replied, said no message had been left or cell phone. view with RN-D at 10:30 a.m. ontacted RN-E who notification the fall. The nurse actually contacted R175's ght the nurse probably E175's family, but then forgot. anager of the unit, stated he be called regarding all falls. Fall Management Investigation of a Fall directed contact family	F	157			

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		AND HUMAN SERVICES			FORM	11/23/2015 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245520	B. WING _		10/	15/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
REDEEN	IER RESIDENCE INC			625 WEST 31ST STREET MINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 176		-	F 17			
F 176 SS=D	DRUGS IF DEEME	NT SELF-ADMINISTER D SAFE	F 17	6		11/24/15
	the interdisciplinary	ent may self-administer drugs if team, as defined by as determined that this				
	by: Based on observative review, the facility for self-administration practice for 1 of 1 medications left at the Findings include: R132 was observed while sitting in a recor- resident was observed while sitting in a recor- resident was whimp containing five pills her, and another pills her another	of medications was a safe esident (R132) observed with the bedside. d on 10/15/15, at 1:29 p.m. cliner in her room. The bering. A medicine cup was on the footrest in front of Il was outside the cup on the fied the pills were hers, and n. odiately summoned the director nd a registered nurse. RN-D only allowed to self-administer . RN-D then discovered R132 the medications, but said the ave left R132 with the		The facilities practice is th may self-administer drugs inter-disciplinary team has that this practice is safe. R132 was discharged on 1 Nurses were educated on self-administration of medi policy and requirements. N report new requests to the who will then ensure requir been met prior to the resid self-administering medicat medication pass audits will by facility and continue to b consultant pharmacy. Responsible for complianc Managers Responsible for overall cor Director of Nursing	if the determined 1/2/2015. the cation (SAM) lurses will nurse manager rements have ent ions. Random I be completed be completed by se: Nurse	

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		AND HUMAN SERVICES				FORM	: 11/23/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY IPLETED
		245520	B. WING	i		10/	15/2015
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
REDEEN	IER RESIDENCE INC				525 WEST 31ST STREET MINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 176 F 225 SS=D	self-administration. 5/5/15, indicated a Medication assess prior to allowing the medications. The c however, self-admin A 1/13, Medication- indicated "All medic by facility staff until has been assessed from the physician f administer and the 483.13(c)(1)(ii)-(iii), INVESTIGATE/REF ALLEGATIONS/INE The facility must no been found guilty of mistreating residen had a finding enterer registry concerning of residents or misa and report any know court of law against indicate unfitness for other facility staff to or licensing authorit The facility must en involving mistreatm including injuries of misappropriation of immediately to the a to other officials in a	R132's care plan dated Self-Administration of ment was to be completed a resident to self-administrate are plan noted R132 could, nister the topical medication. Self Administration policy cations must be administered their ability to self administer d. Staff must obtain an order for a resident to self care plan is to be updated." (c)(2) - (4) PORT DIVIDUALS of employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a t an employee, which would or service as a nurse aide or o the State nurse aide registry ties.		225			11/24/15

Facility ID: 00160

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 11/23/2015 APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DAT	E SURVEY IPLETED			
		245520	B. WING _		10/	15/2015			
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	,				
REDEEM	IER RESIDENCE INC			625 WEST 31ST STREET MINNEAPOLIS, MN 55408					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE			
F 225	The facility must haviolations are thoroup prevent further pote investigation is in pre- The results of all investigation is in pre- to the administrator representative and with State law (inclu- certification agency incident, and if the a appropriate correction This REQUIREMENT by: Based on interview facility failed to immediate administrator and d and to thoroughly in abuse for 2 of 2 rese Findings include: R174 reported he were respect by a nursing interview on 10/13/7 physically described incident happened the morning cares. The "poor attitudeWhe diapers she made a 'What is all that whit the resident cougher hand across your methe other nursing as had told him to cover	ve evidence that all alleged ughly investigated, and must ential abuse while the rogress. vestigations must be reported	F 22	25 It is the practice of the facility to a all employees have the proper background checks and are clear in a healthcare facility. It is also th practice of the facility to follow the mandated procedures regarding vulnerable adults. In regards to the OHFC report for was filed on 10/15/2015, the nurs assistant involved in the allegatio removed from the schedule, and investigation summary was subm within 5 days of the incident repor required. LSW who was made aw the incident for R174 on 10/14/20 been re-educated on the need to resident allegation of verbal abus immediately. R48 had a report filed within 24 h incident and investigative summa with OHFC within 5 days of repor	R174, it ing n was an itted t as vare of 15 has report e ours of ry filed				

Facility ID: 00160

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/23/2015 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
		245520	B. WING			10/1	15/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
REDEEN	IER RESIDENCE INC				25 WEST 31ST STREET IINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	should be checked had made other der and had been indiff he had not reported feel smallI didn't r cannot talk to ignor. During a second co 12:50 p.m. R174 st to the social worker felt he had been ab An interview with a on 10/15/15, at 8:16 told her first on 10/1 during their initial vi did not like the way did not consider this explained R174 sp regarding his treatm felt he was verbally stated she brought corporate represen reportable incident. initiated at this time At 8:33 a.m. the sat interviewed. NA-B morning rounds NA providing care for F assisting R174, NA brief and asked R1 white stuff in there f explained is was the his skin for protection so bad this morning (because he was an light). She added N	for that." R174 said the NA meaning remarks in the past erent toward him. He stated d it to anyone, but it "made me eply, because I realize you ance like that." Inversation on 10/14/15, at ated he reported the incident earlier that day because he used verbally by NA-A. Licensed social worker (LSW) 6 a.m. revealed R174 had 12/15 regarding the incident sit. The LSW stated R174 the NA-A made him feel but s to be abuse. She further oke to her again on 10/14/15 nent and this time stated he abused by NA-A. The LSW it to the attention of the tative and was told it was not a An investigation was not	F 2	225	Staff have been re-educated on the to report immediately. Staff comple OHFC investigations were re-educa- need to include dates and times of interviews conducted during the investigations. All staff are educated upon hire, an and prn on vulnerable adult reportin Responsible for Compliance: Direc Nursing and Administrator	eting ated on nually, ng.	

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		AND HUMAN SERVICES				FORM	11/23/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245520	B. WING			10/ [.]	15/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
REDEEM	IER RESIDENCE INC				25 WEST 31ST STREET /INNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	Continued From pa portrayed this type of stated she had report At 8:49 a.m. R174 st the abuse on Mond abuse but later he of as abuse and stated insignificant." At 8:59 a.m. while end director of nursing (incident was reported She further explained an incident of report the SA immediately reported yesterday. At approximately 9: RN-F was not in the phone. She did not incident. Later that day at 10 spoke with the corp verified the LSW has attention, but did not incident.	age 7 of demeanor often. NA-B ported the situation to RN-F. stated when he first reported lay he did not consider it as did. He reported it to the LSW d it made him "feel explaining the incident the (DON) verified with the ed by the LSW at that time. ed she would have expected ted abuse to be reported to . "This should have been . It is our policy." 32 a.m., RN-D explained e facility but spoke to her by recall NA-B reporting the 0:02 a.m. the DON stated she porate representative and ad brought the allegation to her ot feel it was a reportable	F 2	225	DEFICIENCY)		
	diagnoses including Mental Status score intact cognition (15/	Imitted to the facility with g anxiety. A Brief interview for e dated 10/12/15, revealed /15 possible). otes were reviewed but lacked					
	mention of this incic	dent. ident reports for R174 was					

If continuation sheet Page 8 of 33

		AND HUMAN SERVICES				FORM	: 11/23/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245520	B. WING			10/	15/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
REDEEN	IER RESIDENCE INC				25 WEST 31ST STREET IINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	Continued From pa	ige 8	F 2	25			
	 8/26/15, which reversive swore at the resider 8/25/15. R48 could A documented interdiated 8/26/15, reversive incident to a supervection to a supervection of the investigative restricts of the report did not in the report was not revealed the reside memory problems a staff assistance for personal hygiene, or transferring. On 10/15/15, at 12: (DON) reported NA reporting because to the end of her shift, have expected alleger reported. Although about immediate redocumented the coexplained a previou investigation into Rappropriate personal appropriate personal ap	ert was submitted to the SA on ealed NA-Y reported NA-Z int during evening cares on not recall the event. And the investigative file ealed NA-Y did not report the visor until the following day. Support was not submitted to the ad lacked interviews of is to determine their potential acident or similar allegations. Include a rationale as to why made by NA-Y until the neasures taken to ensure rediately in the future. And short and long term and required staff extensive cares such as bed mobility, dressing, toileting, and And required staff extensive cares such as bed mobility, dressing, toileting, and And required staff extensive cares such as bed mobility, dressing, toileting, and And required staff extensive cares such as bed mobility, dressing, toileting, and And required staff extensive cares such as bed mobility, dressing, toileting, and And required staff extensive cares such as bed mobility, dressing, toileting, and And required staff extensive cares such as bed mobility, dressing, toileting, and And required staff extensive cares such as bed mobility, dressing, toileting, and And required staff extensive cares such as bed mobility, dressing, toileting, and And required staff extensive cares such as bed mobility, dressing, toileting, and And required staff extensive cares such as bed mobility, dressing, toileting, and And required staff extensive cares such as bed mobility, dressing, toileting, and And required staff extensive and require					

If continuation sheet Page 9 of 33

CENTEI STATEMENT AND PLAN C		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245520	. ,	S		FORM MB NO. (X3) DATE COM	11/23/2015 APPROVED 0938-0391 E SURVEY PLETED 15/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	about their knowled being treated and/o similar allegations. review NA-Y's empl reporting of allegatio other investigative i related to R48. The facility's 9/13, M Prohibition Plan dire responsible to repo of mistreatment, ne and/or misappropria immediately to one Supervisor, Nurse of Social Worker. The immediately to the A Report all alleged v incidents immediate agencies as require suspicious bruising patterns and trends and determine the o investigation1. All resident abuse, neg unknown source an resident property sh thoroughly investiga document investiga investigation may ir physical examinatio environment. Exam licensed nurse or pl suspected, call the bathe/wash the resis clothing or linen. Do in which the incident	dge of how residents were or their knowledge of potential The DON reported she would loyee file regarding immediate ons and check to see if any information was available Vulnerable Adult Abuse ected staff: "Each employee is rt suspected/alleged violations eglect, and abuse of residents ation of resident property of the following: Nursing on Duty, Director of Nursing or e administrator will be notified of the above. Staff may go Administrator if desired. iolations and substantiated ely to the SA and all other edIdentify events, such as of residents, occurrences, a that may constitute abuse direction of the reports of suspected/alleged glect, mistreatment, injuries of nd/or misappropriation of nall be promptly and ated. 2. Collect data and tive findings. 3. The nclude but is not limited to: on of the resident and nination of the resident by a hysician. IF sexual abuse is police immediately. DO NOT ident or wash the resident's o not take items from the area	F 2	225			

Facility ID: 00160

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	()	E SURVEY PLETED
ID PLAN C	F CORRECTION	IDENTIFICATION NUMBER.	A. BUILD	ING	COM	PLETED
		245520	B. WING			15/2015
IAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 625 WEST 31ST STREET	CODE	
REDEEN	IER RESIDENCE INC			MINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETIC DATE
F 225 F 226 SS=D	for events leading uperson(s) reporting alleged victim. Interview Interview other resi perpetrator provide completed docume 483.13(c) DEVELO ABUSE/NEGLECT The facility must de policies and proced mistreatment, negle	up to incident. Interview the the incident. Interview the view any potential witness to ew the alleged perpetrator. dents to whom the alleged s care or services. Review the ntation." P/IMPLMENT , ETC POLICIES	F 2			11/24/15
	by: Based on interview facility failed to follo and report immedia designated State ag investigate allegatio residents reviewed ensure background before 3 of 18 newl direct care services Findings include: The facility's 9/13, V Prohibition Plan dire responsible to repo of mistreatment, ne and/or misappropria	NT is not met as evidenced y and document review, the w abuse prohibition policies tely to the administrator and gency (SA) and thoroughly ons of verbal abuse for 2 of 2 (R174, R48); and failed to checks were completed y hired employees provided to residents. /ulnerable Adult Abuse ected staff: "Each employee is rt suspected/alleged violations glect, and abuse of residents ation of resident property of the following: Nursing		It is the practice of the fact mandated reporting proced relates to Vulnerable Adults incident is of known origin, guidelines, it is not reportal unknown incident. Such wa R73. It is also the practice of the conduct background check employees prior to allowing unsupervised within the fac Regarding R48, a report wa 24 hours of incident and pe guidelines an investigative with OHFC within 5 days of a report of verbal abuse.	lures as it s. When an per VA ble as an as the case with facility to s on all them to work cility. as filed within er reporting summary filed	

Facility ID: 00160

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MU	י וסוד	E CONSTRUCTION		0938-039 SURVEY			
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED			
		245520	B. WING			10/*	15/2015			
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE					
REDEEM	ER RESIDENCE INC			625 WEST 31ST STREET MINNEAPOLIS, MN 55408						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE			
F 226	immediately by one immediately to the Report all alleged v incidents immediate agencies as require suspicious bruising patterns and trends and determine the investigation1. All resident abuse, neg unknown source ar resident property sk thoroughly investigat document investigat investigation may ir physical examination environment. Exam licensed nurse or p suspected, call the bathe/wash the ress clothing or linen. Do in which the incider documentation and for events leading u person(s) reporting alleged victim. Intervie Interview other resis perpetrator provide completed docume directed, "Screen a history of abuse, ne misappropriation of hiring process. Scree limited to: Criminal	e administrator will be notified e of the above. Staff may go Administrator if desired. riolations and substantiated ely to the SA and all other edIdentify events, such as of residents, occurrences, s that may constitute abuse	F 2	26	protocol to immediately report VA concerns and to include dates and of investigative interviews was com in October, November and is on-ge staff are educated upon hire, annu and prn on vulnerable adult reporti Responsible for compliance: Mana DON, and Administrator Regarding employee background of the procedure as been revised and educated on the proper timing and supervision guidelines. Responsible persons: HR Manage managers and Administrator.	ducted bing. All ally, ng. ugers, checks, d staff				

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		AND HUMAN SERVICES				FORM	11/23/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
		245520	B. WING			10 / [.]	15/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
REDEEM	IER RESIDENCE INC				25 WEST 31ST STREET /INNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	interview on 10/13/ ⁻ physically described incident happened to morning cares. The "poor attitudeWhe diapers she made a 'What is all that whi the resident coughe hand across your m the other nursing as had told him to cove added, "He probabl should be checked had made other der and had been indiffe he had not reported feel smallI didn't r cannot talk to ignora During a second co 12:50 p.m. R174 sta to the social worker felt he had been ab An interview with a on 10/15/15, at 8:16 told her first on 10/1 during their initial via did not like the way did not consider this explained R174 sp regarding his treatm felt he was verbally stated she brought corporate represent reportable incident. initiated at this time	15, at 3:03 p.m. The resident d the NA. He stated the the morning of 10/11/15 during e resident said the NA had a en she was changing my a comment to demean me, ite stuff coming out?." When ed she told him to "Put your nouth!" She then turned the ssistant (NA)-A and stated she er his mouth before and by has TB [tuberculosis]. He for that." R174 said the NA meaning remarks in the past erent toward him. He stated d it to anyone, but it "made me reply, because I realize you ance like that." onversation on 10/14/15, at ated he reported the incident r earlier that day because he sused verbally by NA-A. licensed social worker (LSW) 6 a.m., revealed R174 had 12/15 regarding the incident sit. The LSW stated R174 the NA-A made him feel but s to be abuse. She further soke to her again on 10/14/15 nent and this time stated he abused by NA-A. The LSW it to the attention of the tative and was told it was not a An investigation was not	F2	226			

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		AND HUMAN SERVICES				FORM	11/23/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245520	B. WING			10/ [.]	15/2015
NAME OF F	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
REDEEM	IER RESIDENCE INC				25 WEST 31ST STREET IINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	interviewed. NA-B morning rounds NA providing care for F assisting R174, N/ brief and asked R17 white stuff in there [explained is was the his skin for protection so bad this morning (because he was an light). She added N statements in the pro- portrayed this type of stated she had report At 8:49 a.m. R174 st the abuse on Mond abuse but later he of as abuse and stated insignificant." At 8:59 a.m. while ed director of nursing (the incident at that the she would have exp abuse to be reported should have been re- policy." At approximately 9: RN-F was not in the phone. She did not incident. Later that day at 10 spoke with the corp verified the LSW has	stated on 10/12/15, during A-A asked for assistance with R174. While they were A-A removed his incontinent 74 "What is all that yucky [incontinent brief]?" NA-B e cream they had applied to on. NA-A then stated "He was g, he was like an asshole" nxious and kept turning on his IA-A had made these resence of the resident, and of demeanor often. NA-B borted the situation to RN-F.	F 2	26			

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		AND HUMAN SERVICES				FORM	: 11/23/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245520	B. WING			10/	15/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
REDEEM	IER RESIDENCE INC			-	25 WEST 31ST STREET /INNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	Continued From pa	ge 14	F 2	26			
	diagnoses including	Imitted to the facility with g anxiety. A Brief interview for e dated 10/12/15, revealed /15 possible).					
	Nursing progress no mention of this incic	otes were reviewed but lacked dent.					
	A request for all inci requested but was r	ident reports for R174 was not provided.					
	8/26/15, which reve swore at the resider	rt was submitted to the SA on ealed NA-Y reported NA-Z nt during evening cares on not recall the event.					
	dated 8/26/15, reve incident to a superv The investigative re SA until 8/31/15, an appropriate persons knowledge of the in The report did not in the report was not re following day, nor m	view in the investigative file valed NA-Y did not report the visor until the following day. eport was not submitted to the d lacked interviews of s to determine their potential incident or similar allegations. Include a rationale as to why made by NA-Y until the neasures taken to ensure ediately in the future.					
	revealed the resider memory problems a staff assistance for	ta Set (MDS) dated 8/12/15, nt had short and long term and required staff extensive cares such as bed mobility, dressing, toileting, and					
	(DON) reported NA	27 p.m. the director of nursing -Y may have delayed he incident did not occur until					

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CENTER STATEMENT AND PLAN C		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245520	• •	ING _		FORM / MB NO. (X3) DATE COMI	11/23/2015 APPROVED 0938-0391 E SURVEY PLETED 15/2015
REDEEN	IER RESIDENCE INC				25 WEST 31ST STREET MINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	have expected alleg reported. Although about immediate re documented the co explained a previou investigation into Re appropriate persons again, had not beer verified other reside and staff persons s about their knowled being treated and/o similar allegations. review NA-Y's emp reporting of allegati other investigative i related to R48. Review of E1's emp working at the facili check was complet "may provide direct facility without conti schedule revealed I supervision by anot until 7/22/15, and the without direct super Review of the time worked 19 shifts with between 7/22/15 ur background check of Review of E2's emp working at the facili check was complet provide direct conta without continuous	The DON reported she would gations to be immediately she had spoken to NA-Y porting, she had not nversation. The DON is manager had completed the 48's allegation, and believed s had been interviewed, but n documented. The DON ents or their family members hould have been interviewed lge as to how residents were ir their knowledge of potential The DON reported she would loyee file regarding immediate ons and check to see if any nformation was available bloyee file revealed E1 started ty on 7/9/15. E1's background ed on 8/31/15, verifying E1 contact services for the nuous supervision." The daily E1 worked under continuous ther staff member from 7/9/15 hen worked in her position rvision from another staff. detail report revealed E1 thout continuous supervision ntil she passed her	F2	226			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/23/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245520	B. WING			10 /*	15/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
REDEEM	ER RESIDENCE INC				25 WEST 31ST STREET IINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226 F 279 SS=D	until 8/14/15. Revie revealed E2 worked continuous supervis results came back of Review of E3's emp working at the facili background check of verifying the employ contact services for supervision." The d worked under contin staff member from of the time detail re shift without continu- passed her backgro On 10/14/15, at 3:0 worker verified E1, facility providing dire without continuous background checks 483.20(d), 483.20(k COMPREHENSIVE A facility must use t to develop, review a comprehensive plan The facility must de plan for each reside objectives and time medical, nursing, an needs that are iden assessment.	her staff member from 8/4/15 w of the time detail report d nine shifts without sion until background check on 9/1/15. oloyee file revealed E3 started ty on 8/18/15. E1's was completed on 9/3/15, yee "may provide direct t the facility without continuous aily schedule revealed E3 nuous supervision by another 8/18/15 until 8/31/15. Review port revealed E3 worked 1 uous supervision until she ound check on 9/3/15. 4 p.m. the human resource E2 and E3 worked at the ect care services to residents supervision prior to their s being complete. s)(1) DEVELOP E CARE PLANS he results of the assessment and revise the resident's n of care.	F 2		DEFICIENCY)		11/24/15
	assessment.	describe the services that are					

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES			OMB NO.	APPROVEI 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245520	B. WING _		10/	15/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
REDEEM	IER RESIDENCE INC			625 WEST 31ST STREET MINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 279	highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident' §483.10, including funder §483.10(b)(4 This REQUIREMEN by: Based on observat review the facility fa developed for 1 of 3 activities of daily liv Findings include: R59's care plan lack dependence on sta bathing. An inconti resident was at risk R59 was observed 1:30 p.m. Her was a uncombed. A strong in the room. On 10 p.m. there was no c appearance and a to On 10/14/13, at 8:3 R59, she stated the incontinent issues t well as with weekly face each day. She	 Attain or maintain the resident's physical, mental, and peing as required under ervices that would otherwise \$483.25 but are not provided s exercise of rights under the right to refuse treatment the right to refuse treatment .). NT is not met as evidenced tion, interview and document ailed to ensure a care plan was 3 residents (R59) reviewed for ing. ked direction to staff as to how ent was kept clean and odor ed identification of her ff for personal hygiene and nence care plan noted the 	F 27	 It is the facilities practice to use results of the assessment to devreview and revise the resident as comprehensive plan of care. R59 had an ADL care plan devering place on 10/15/2015. An audit completed on 10/19/2015 for all residents in the facility to ensure care plan was in place for each, audits will be completed for new admissions to ensure an ADL care in place by day 21 of their nursing stay. Quality Assurance Commit review audit results and determit frequency and duration of audits. Responsible for compliance: Nu Managers Responsible for overall compliant complian	elop, oped and was other an ADL Random re plan is g home cee will ne	

		AND HUMAN SERVICES & MEDICAID SERVICES			F	FORM	11/23/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				K3) DATE	E SURVEY PLETED
		245520	B. WING			10/*	15/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
REDEEM	ER RESIDENCE INC				25 WEST 31ST STREET IINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 279 F 312 SS=D	following day at 8:4 still unclean and un noted. At that time not know when her R59's quarterly Min revealed the resider required extensive a use, and personal h always incontinent of the assessment read during the entire per resist care during th On 10/15/15, at 9:3 (RN)-B reviewed the was not included in been. A related policy was provided. 483.25(a)(3) ADL C DEPENDENT RES A resident who is un daily living receives maintain good nutrin and oral hygiene. This REQUIREMEN by: Based on observat review, the facility fa services to ensure for	A requested, but was not care plan, but should have a requested, but was not care plan, but should have a requested, but was not care plan and verified ADLs the plan, but should have a requested, but was not care plan and verifies of the necessary services to tion, grooming, and personal	F3	279	It is the facility's policy that a resident is unable to carry out activities of dail living receives the necessary services	ly s to	11/24/15
	Based on observat review, the facility fa services to ensure r	ailed to provide hygiene			is unable to carry out activities of dail	ly s to	

Facility ID: 00160

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CENTEI STATEMENT AND PLAN C	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245520 TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		S S S N	ON	FORM / //B NO. (X3) DATE COM 10/1	11/23/2015 APPROVED 0938-0391 E SURVEY PLETED 15/2015
F 312	dependent on staff activities of daily livi Findings include: R59 was observed 1:30 p.m. Her was a uncombed. A strong in the room. On 10 p.m. there was no c appearance and a u On 10/14/13, at 8:3 R59, she stated the incontinent issues t well as with weekly face each day. She bathing routine. The greasy/uncombed h following day at 8:4 still unclean and un noted. At that time not know when her R59's quarterly Min revealed the reside required extensive use, and personal h always incontinent the assessment rea during the entire per resist care during th The care plan for R to how to ensure th odor free. The plan dependence on sta	in her room on 10/12/15, at appeared greasy and was g smell of urine was detected /13,14, at 12:30 p.m. and 5:30 change in the resident's urine odor was present. 0 a.m. during an interview e staff helped her with her o change and clean up, as showering and washing her e was satisfied with her e resident again had nair and smelled of urine. The 5 a.m. the resident's hair was combed and a urine odor was the resident reported she did scheduled bath day. imum Data Set (MDS) nt was cognitively intact, and assistance with dressing, toilet nygiene. She was noted as of urine. The bathing portion of ad, "Activity itself did not occur riod." The resident did not ne assessment period. 59 lacked direction to staff as e resident was kept clean and lacked identification of her ff for personal hygiene and nence care plan noted the	F	312	personal and oral hygiene. R59 had directions on the nursing assistants' group sheet to provide st assist with ADL care and this is now included on the resident's care plan plan was put into place on 10/15/20 Random ADL audits to be complete weekly. Quality Assurance Committe review audit results and determine frequency and duration of audits. Responsible for compliance: Nurse Managers Responsible for overall compliance: Director of Nursing	, . Care 15. d ee will	

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	DIE CONSTRUCTION (X3) DA	TE SURVEY
	DF CORRECTION	IDENTIFICATION NUMBER:			MPLETED
		245520	B. WING _	10	/15/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
REDEEN	IER RESIDENCE INC			625 WEST 31ST STREET MINNEAPOLIS, MN 55408	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 312	Continued From pa	ge 20	F 31	2	
	(RN)-B reported sh of urine and that he uncombed. She sa	0 a.m. a registered nurse e was unaware R59 smelled r hair was unclean and id the staff was responsible as assisted with incontinence n good hygiene.			
F 364 SS=E	provided.	s requested, but was not ITRITIVE VALUE/APPEAR, ER TEMP	F 36	4	11/24/15
	food prepared by m	ves and the facility provides ethods that conserve nutritive opearance; and food that is and at the proper			
	by: Based on observat review the facility fa served at palatable resident (R160) who	NT is not met as evidenced ion, interview and document iled to ensure food was temperatures for 1 of 1 to requested food reheated		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	
	and potentially the other 14 residents in the 2W dining room. Findings include:			 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 	
	10/12/15, at 12:00 p dietary aide (DA)-A two metal food war covered with foil, bu plugged in the food	tions were conducted on b.m. in the 2W dining room. A entered the dining room with mers that had food containers at no metal covers. DA-A then warmers, and instead of food covered to ensure		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 resident	r

Facility ID: 00160

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.			
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONSTRUCTION		E SURVEY PLETED		
		245520	B. WING _		10/	15/2015		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E			
REDEE	IER RESIDENCE INC			625 WEST 31ST STREET MINNEAPOLIS, MN 55408				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE		
F 364	maximum temperat covers were remove taken of the individue temperatures, howe metal probe touches stated it was the wat temperatures with t pan. The corn regist (F), and chicken nor registered 140 degr foods should have they did not he heat asked for food to be At 12:19 p.m. R160 of food from the tak room to re-heat her place between DA- how long the food r staff person then as the plate of food. R "My meat was not w DA-A to measure th pork rib and it regis heated in the micro then proceeded to repotatoes, and mixe the microwave for t to R160. A second with foil was hand of The riblets registered proceeded to individue served of riblets, poor or corn to the rest of yet been served in the dining service. At 1 the food warmers rest	tures were maintained, the foil ed. Temperatures were then ual foods. When taking the ever, a click was heard as the ed the bottom of the pan. DA-A ay he usually measured food he probe on the bottom of the stered 120 degrees Fahrenheit odle and tomato soup rees. DA-A reported the hot registered 160 degrees, and if ted foods when residents	F 3(64 will be reminded that staff are reheat food whenever necessa Resident Food Committee and Satisfaction surveys will also b gain feedback from residents a level of satisfaction. Audits wil reviewed at Quarterly Q.A. me Dietary staff were re-trained of procedures during the week of Dietary manager is responsibl on-going compliance.	ary. The d Customer be utilized to as to their be etings. h proper f 10/12/15.			

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		AND HUMAN SERVICES				FORM	11/23/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245520	B. WING			10/ [.]	15/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
REDEEM	IER RESIDENCE INC				25 WEST 31ST STREET /INNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 364	temperatures were the dining director (pan of pork riblets s the kitchen at 170 d informed the DD that degrees after arrival stated she did not k been immediately d a delay due to the e an announcement h loudspeaker to keen mealtime. The following day a "My food is frequen my food up in the m guess it is somethin do your self." R160 "right away" and sat was present to see hot enough. At the noon meal at a food cart with two top with foil covering warmer and proceet temperatures of the as the probe toucher when the meatloaf to DA-C pulled the foil and did not partially Hamburger register registered 123 degr registered 140 degr the temperatures on a l however, were writt different from that for	age 22 re-taken. Five minutes later DD) reported that the second sent to replace the first pan left degrees. The surveyor then at the riblets measured 130 al when DA-A measured it. DD know whether the riblets had delivered, or whether there was elevators being busy. She said had been made over the p the elevators free during at 11:41 a.m. R160 reported, thy coolnot hot enough. I heat nicrowave quite oftenSo I ng you have to put up with and stated she usually was served id she was glad the surveyor the food was not being served at 12:06 p.m. DA-C brought up o metal warmers placed on the gs. DA-C then plugged in the eded to measure the e food. A click was again heard ed the bottom of the metal pan temperature was measured. I back from the individual pans or re-cover the food. red 120 degrees, chicken legs rees and chicken noodle soup rees. The surveyor reviewed fter DA-C had recorded the log. The temperatures, ten on different columns oods' column. When asked res were recorded as they	F3	364			

Facility ID: 00160

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES		TID	0	FORM. MB NO.	11/23/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION		E SURVEY PLETED
		245520	B. WING			10/*	15/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
REDEEM	IER RESIDENCE INC				25 WEST 31ST STREET /IINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 364	were, DA-C replied temperature anywh on the log." DA-C a dining rooms used serve the food, as t kitchenettes. When and chicken legs te the policy directed, would have warmed request. At 12:32 p.m. DD s yesterday, I re-told today to put plastic during transport, an during the meal ser when all staff had b were not in use in th would continue to n change from steam to the use of the wa ago, and they had r Vollrath (brand nam instructions. On 10/14/15, at 8:4 utilized to cover foo DA-B stated she alw on the warmers, bu differently" with som the food with foil. D been taught by the covers. In addition ensure the metal pr metal pan when tak the entire food was whether measuring	 , "I sometimes write the ere as there is no place for it also stated only 2W and 3W warmers to transport and the other dining rooms had a asked about the hamburger emperatures being lower than DA-C explained that she d the food per resident tated, "Since we talked the staff in morning meeting covers on the warmers" and to keep the food covered vice. She was unsure why been trained, that the covers he 2W dining room, but she nonitor the situation. The tables in the two dining areas armers had started just a year not maintained the Cayenne he) manufacturer's A a.m. plastic covers were ods at the breakfast meal. ways used the plastic covers it that dietary staff "work ne dietary staff just covering DA-B also reported she had DD to utilize the plastic, they were supposed to robe touched the bottom of the king temperatures, to ensure warm. DA-B was unsure if the metal probe touching the would potentially erroneously 	F	864			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	11/23/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245520	B. WING		10/ [.]	15/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
REDEEM	ER RESIDENCE INC			625 WEST 31ST STREET MINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 364	Continued From pa	ge 24	F 36	4		
F 431 SS=D	the 2W dining room observed being tran covers off the pans inches, as there we pans stacked, thus fitting snuggly. Three stacked on lower pa- with the hot water in DA-B plugged in the temperatures. Chic degrees and tomate degrees. When ask DA-B stated, "110 c After the meal DD s touch the bottom of verified the metal p directly in contact w warmer. Policies regarding f was requested but 483.60(b), (d), (e) D LABEL/STORE DR The facility must en a licensed pharmace of records of receip controlled drugs in a accurate reconciliant reconciled. Drugs and biological labeled in accordant	hat same day at 12:01 p.m. in a, food warmers were asported with the plastic as much as four to five as only registered stafe and were not in contact thended to keep the food hot. as warmers and measured food ken soup registered 112 as oup registered 118 and about the temperatures legrees is okay for soup." atated she had trained staff to the pan with the probe. DD ans should have all been with the hot water in the ood temperatures and serving not provided by the facility. DRUG RECORDS, UGS & BIOLOGICALS and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be alse with currently accepted alles, and include the	F 43	1		11/24/15

Facility ID: 00160

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		AND HUMAN SERVICES & MEDICAID SERVICES	FORM APPROVED OMB NO. 0938-0391					
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED	
		245520	B. WING	à		10 /1	15/2015	
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
REDEEN	IER RESIDENCE INC				625 WEST 31ST STREET MINNEAPOLIS, MN 55408			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 431	applicable. In accordance with facility must store a locked compartmer controls, and permi have access to the The facility must pro- permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distril quantity stored is m be readily detected. This REQUIREMEN by: Based on observat review the facility fa medication was not residents (R10, R18 inhalers (to aid in bud destroyed after they insulin pens were n according to manuf resident (R114) who temperature. Findings include: 1) R10's Advair Dise	State and Federal laws, the Il drugs and biologicals in its under proper temperature t only authorized personnel to keys. Divide separately locked, I compartments for storage of ed in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the inimal and a missing dose can	F 4	43	It is the facilities practice to employ obtain the services of a licensed pharmacist who establishes a syste records of receipt and disposition of controlled drugs in sufficient detail to enable an accurate reconciliation ar determines that drug records are in and that an account of all controlled is maintained and periodically record Advair inhalers for R10 and R18 we removed from the medication cart a disposed of on 10/14/2015 during si For R114 insulin pens were dispose and insulin replaced. The only resid	m of f all o order drugs aciled. re und urvey. ed of		

Facility ID: 00160

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PRINTED: 11/23/2015

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	1		OMB NO.	APPROVE 0938-039		
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED		
		245520	B. WING _		10/	15/2015		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE			
REDEEN	IER RESIDENCE INC			625 WEST 31ST STREET MINNEAPOLIS, MN 55408				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE		
F 431	the 2W medication medication storage registered nurse (R dose remaining, an medication twice da staff had been train were opened, but w lacked an opened of long the Advair would unlabeled, would us inhaler. 2) R18's Advair Dis stored for use on the lacked an opened of medication had beed dated when opened 3) R114's Nov 70/3 (for diabetes) were temperature on the refrigerated accord recommendations. the 2W medication are supposed to be they had not been of of the refrigerator a case I needed them sugar checks three needed the medica readings. A short time later R medication room ca RN-A said two of th inhalers for R10 an with a sticker indica	cart was observed for 10/14/15, at 9:47 a.m. A N)-A verified there was one of explained R10 utilized the aily. RN-A reported nursing ted to date inhalers when they was unsure why the Advair date. RN-A was unsure how and have been effective once use the pharmacy label and if se the expiration date on the cus was also opened and the 2W medication cart, but date. RN-A verified the en opened, but had not been	F 43	the unit with insulin pens had replaced. Nurses responsible administering the Advair and re-educated on facility policy to of medications and dating iter opened as indicated. Tubercu during survey was destroyed. medication storage and medi audits will be completed and to monthly by the QA team who determine frequency and dura audits. Responsible for compliance: Managers and Staff Educatio Responsible for overall comp Director of Nursing	for insulin were for expiration ns when llin vial noted Random cation pass reviewed will then ation of Nurse n.			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/23/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DAT	E SURVEY PLETED
		245520	B. WING	i		10/	15/2015
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
REDEEN	IER RESIDENCE INC			-	625 WEST 31ST STREET MINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 431	destroyed after 10/8 pharmacy label that of opening" and wa medication should f 9/5/15. 4) The next observa medications on the Tubersol (for tuberco opened 4/11/15. RN been opened and a medication was left she was unaware h used once it had be of any reference sh directed the staff. R expiration date on t dated 3/16, and was no thermometer. Th refrigerator had a th degrees Fahrenheit the medication coul degrees, but was un may have affected f RN-A said nurses w responsible for cheat temperatures. A laminated listing f at the nursing static should have been co opening. On 10/14/15, at 2:3 (DON) stated nurses at each nurses statt medication efficacy shortened use date	B/15. R18's bag had a t read "Dispose after 30 days s dated as opened 8/7/15. The nave been disposed of after ation was of refrigerated unit. A multi-use vial of culin skin testing) was dated as V-A verified the bottle had pproximately 1/3 of the in the bottle. RN-A reported ow long Tubersol could be een opened, and was unaware eet available that would have N-A stated she would use the he bottle. The bottle was s stored in a refrigerator with	F	431			

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		AND HUMAN SERVICES				FORM	11/23/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245520	B. WING	i		10/	15/2015
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
REDEEM	IER RESIDENCE INC				625 WEST 31ST STREET MINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	between 36 to 46 d with shaded instructions as that were found out called RN-B, who ir temperature gauge The DON also expl check the temperature check the temperature check the temperature check the temperature of the 2W medication 10/15 indicated the range at 32 degrees degrees on 10/2. The undated Merwi Storage and Expirat the facility directed UnopenedRefrige tuberculin testing] F Expiration Date 30 Discus Date When Days After Foil Oper temperature=36-46 A 1/27/15, Medicatii policy indicated, "M refrigeration are key from 36-46 degrees	I have been maintained egrees. New temperature logs tions were going to be added, to how to adjust temperatures of range. The DON then how to adjust temperatures of range. The DON then had already been adjusted. ained the night nurses were to ures and day nurses were to ures and day nurses were to ures if the night nurse had he temperature. g provided by the facility for refrigerator for the month of refrigerator had been out of s on 10/1/15, and at 34 n LTC Pharmacy Medication tion Guidelines provided by staff as follows: "Insulin Pens ratorTuberculin PPD [for Refrigerator Date When Open Days After 1st UseAdvair Open Expiration Date 30 enedRefrigerator	F 4	431			
F 441 SS=D	483.65 INFECTION SPREAD, LINENS	I CONTROL, PREVENT	F 4	441			11/24/15
		tablish and maintain an ogram designed to provide a					

If continuation sheet Page 29 of 33

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COM	PLETED
	245520	B. WING _		10/*	15/2015
ROVIDER OR SUPPLIER					
ER RESIDENCE INC			MINNEAPOLIS, MN 55408		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETIC DATE
safe, sanitary and c to help prevent the of disease and infec (a) Infection Contro The facility must es Program under whic (1) Investigates, con in the facility; (2) Decides what pr should be applied to (3) Maintains a reco actions related to in (b) Preventing Spre (1) When the Infect determines that a re prevent the spread isolate the resident. (2) The facility must communicable dise from direct contact direct contact will tra (3) The facility must hands after each di hand washing is inc professional practic (c) Linens Personnel must har transport linens so	comfortable environment and development and transmission ction. I Program tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective fections. ad of Infection ion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which dicated by accepted re.	F 44			
	PROVIDER OR SUPPLIER ER RESIDENCE INC SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa safe, sanitary and c to help prevent the of disease and infec (a) Infection Contro The facility must es Program under white (1) Investigates, con in the facility; (2) Decides what pr should be applied to (3) Maintains a reco actions related to in (b) Preventing Spree (1) When the Infect determines that a re- prevent the spread isolate the resident. (2) The facility must communicable dise from direct contact direct contact will tr. (3) The facility must hands after each di hand washing is inco- professional practic (c) Linens Personnel must har transport linens so a	PROVIDER OR SUPPLIER ER RESIDENCE INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	A. BUILLIN 245520 B. WING ROVIDER OR SUPPLIER ER RESIDENCE INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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(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 will transmit the disease. (2) The facility must require staff to wash their handwashing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and</td> <td>A BULLING 10/* ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ER RESIDENCE INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDER'S PLANOF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PROVIDER'S PLANOF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PROVIDER'S PLANOF CORRECTIVE ACTION (EACH DEFICIENCY MUST add, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. F 441 F 441 Continued From page 29 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. F 441 (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 infection. (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 with resident contact for which hands after each direct resident contact for which hands after each direct resident contact for which hands after each direct resident contact for which hands after each dir</td>	A BOILING ROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE CONTREMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (BACH DEFICIENCIES (EACH DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 F 441 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 will transmit the disease. (2) The facility must require staff to wash their handwashing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	A BULLING 10/* ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ER RESIDENCE INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDER'S PLANOF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PROVIDER'S PLANOF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PROVIDER'S PLANOF CORRECTIVE ACTION (EACH DEFICIENCY MUST add, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. F 441 F 441 Continued From page 29 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. 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Facility ID: 00160

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						0938-039
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		245520	B. WING		10/1	15/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
REDEEN	IER RESIDENCE INC			625 WEST 31ST STREET MINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	procedures were for spread of infection observed blood glu affecting a second was also utilized. In administered in a s residents (R66) wh was observed. Findings include: R57's blood sugar 11:56 a.m. by a reg the check was com Wipe germicidal clo 3-4 seconds, and th of the medication c was the usual man RN-A said it was he glucometer for five RN-A also reported the current time by recently "audited" h how she cleaned th auditing process. At 1:05 p.m. a licent reported she wiped with the Sani Wipe. Wipe around the gl The surveyor then indeed meant three stated, "three second Thirty minutes latent to clean glucometer the manufacturer's referred to the instr	blowed to minimize the risk for for 1 of 1 resident (R57) cose test and additionally resident for whom the device addition, medication was not anitary manner for 1 of of 5 ose medication administration was checked on 10/14/15, at istered nurse (RN)-A. After pleted, RN-A used a Sani oth to clean the glucometer for hen set the glucometer on top art. RN-A was asked if this ner for cleaning glucometers. er usual practice to wipe the seconds before and after use. I the glucometer was used at two residents. The facility had her on this, and stated it was he glucometer during the sed practical nurse (LPN)-B the entire glucometer all over , and then wrapped the Sani ucometer for three seconds. clarified with LPN-B if she e seconds and LPN-B again	F 44	1 designed to provide a safe, sanita comfortable environment and to h prevent the development and transmission of disease and infect RN-A and LPN-B along with nursir have been re-educated on the disi procedure for glucometers and on proper handling of medications an infection control measures to be u during a medication pass. Randor of glucometer disinfecting and me passes will be completed and will reviewed monthly by the QA Comr who will then determine frequency duration of audits. Responsible for compliance: Infect control nurse and nurse managers Responsible for overall compliance Director of Nursing.	elp ion. ng staff nfectant the d sed n audits dication be nittee and	

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		AND HUMAN SERVICES				FORM	: 11/23/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245520	B. WING			10/	15/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
REDEEM	IER RESIDENCE INC			-	25 WEST 31ST STREET IINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	wrapping the wipe a leaving it for two mi At 1:58 p.m. RN-C at the facility. She s wiped "real good" a unsure how long the or stay wet, and how prior to use on anot R66's calcium/vitan by RN-A on 10/14/1 washing her hands the tablet with her b the usual method s and she was unsure in half without touch breaking the tablet R66 to swallow. Following the obser (DON) was interviet have followed manus sanitizing the gluco audits to ensure co with nurses. The D0 expected a nurse w medication with the A 3/19/12, Blood Gil policy directed staff maintain cleanlines (glucometer) and pi with blood-borne pa resident useDisin a. Remove the EPA Agency] approved of	d have remained wet by around the glucometer and inutes. reported being recently hired stated glucometers should be and left to air dry. RN-C was e glucometer should be wiped w long it needed to be air dried ther resident. nin D3 tablet was administered 15, at 8:35 a.m. Without or using alcohol gel, RN-A cut oare hands. RN-A said it was he used to break the tablets, e how to break the medication hing it. The rationale for was that it was "easier" for rvation, the director of nursing wed, and said nurses should ufacture's instructions for meters, and verified related mpliance had been conducted ON further explained it was yould not touch a resident's	F 4	141			

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		AND HUMAN SERVICES			FORM	: 11/23/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245520	B. WING _		10/	15/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
REDEEN	IER RESIDENCE INC			625 WEST 31ST STREET MINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	strip port. c. Allow t (glucometer) to com manufacturer's dire [minimize the risk o Virus], other viruses the next blood gluco A 1/27/15, Medicati Guidelines policy no necessary to admir must be washed wi	nt, code ship port, and the test he Blood Glucose Meter npletely dry (according to ections to mitigate HIV of Human Immunodeficiency s and bacteria) before doing	F 44			

Facility ID: 00160

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		AND HUMAN SERVICES & MEDICAID SERVICES	Ť	FF.	5520024	FORM	11/19/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 1 - BUILDING 01	(X3) DATE COM	E SURVEY PLETED
		245520	B. WING			10/2	20/2015
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 5 WEST 31ST STREET		
REDEEM	IER RESIDENCE INC				NNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	rs	К0	000			
	ALLEGATION OF (DEPARTMENT'S A	POC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST					
	PAGE OF THE CM VERIFICATION OF	S-2567 WILL BE USED AS COMPLIANCE.					
-	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN	×				1
	ACCORDANCE W	ITH YOUR VERIFICATION. Survey was conducted by the					n Herr
	Marshal Division or of this survey, Red not in substantial cor requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National	articipation in at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),					11 - 11 - 11 - 11 - 11 - 11 - 11 - 11
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY			EPO		
	Healthcare Fire Ins State Fire Marshal 445 Minnesota St., St. Paul, MN 55107	Division Suite 145					
	By email to: Marian.Whitney@s	tate.mn.us					
	y director's or provit nically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE 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.

		AND HUMAN SERVICES & MEDICAID SERVICES			O		APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - BUILDING 01	(X3) DATE COMF	SURVEY PLETED
		245520	B. WING			10/2	20/2015
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 25 WEST 31ST STREET		
REDEEM	ER RESIDENCE INC				AINNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	THE PLAN OF CO	RRECTION FOR EACH	K	000			
	1. A description of to correct the defici	what has been, or will be, done iency.					
	2. The actual, or pr	oposed, completion date.	21			1	
		r title of the person rection and monitoring to ence of the deficiency.					
	full basement. The different times. The constructed in 1960 Type II(222) constr addition was const determined to be o 1995, a 3 story add East that was dete construction. Beca the 2 additions are	nce is a 3-story building with a building was constructed at 3 e original 3 story building was 0 and was determined to be of ruction. In 1975, a 3 story ructed to the South that was of Type II(222) construction. In dition was constructed to the rmined to be of Type II(222) use the original building and of the same type of acility was surveyed as one					
	has a fire alarm sy the corridors and s that is monitored for notification. The fa	y fire sprinklered. The facility stem with smoke detection in spaces open to the corridors or automatic fire department cility has a capacity of 129 ensus of 114 at the time of the	×				
	The requirement a NOT MET as evide	it 42 CFR, Subpart 483.70(a) is enced by:	÷.			x	

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Facility ID: 00160

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PRINTED: 11/19/2015

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	CONSTRUCTION		
ND PLAN OI	CORRECTION	IDENTIFICATION NUMBER:	A, BUILDII	NG 0 ′	1 - BUILDING 01	COM	LEIED
		245520	B. WING			10/2	20/2015
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
REDEEM	ER RESIDENCE INC				5 WEST 31ST STREET INNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 025	Continued From pa	ge 2	KO	25			
K 025 SS=E		FETY CODE STANDARD	K 0	25			10/21/15
	least a one half hou accordance with 8.3 terminate at an atri- protected by fire-ra panels and steel fra separate compartm floor. Dampers are penetrations of smo	e constructed to provide at ur fire resistance rating in 3. Smoke barriers may um wall. Windows are ted glazing or by wired glass ames. A minimum of two hents are provided on each not required in duct oke barriers in fully ducted , and air conditioning systems 19.1.6.3, 19.1.6.4					- - - - - - -
	Based on observa facility failed to pro- construction that m NFPA 101 - 2000 e	s not met as evidenced by: tion and staff interview, the vide smoke barrier walls neets the requirements of dition, Sections 19.3.7.3 and practice could affect 30			The penetration described in this observation has been properly caul with fire rated material according to standards. Responsible person: Director on Maintenance	lked NFPA	
1	Findings include:						
	on 10/20/2015, it w Wing smoke barrie around conduits th	ween 11:30 AM and 3:30 PM was observed that the 3 East er wall had penentrations at were not properly sealed erial not in accordance with					
	This deficient pract Maintenance Supe	tice was confirmed by the					

Facility ID: 00160

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORMA	11/19/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION 01 - BUILDING 01	(X3) DATE COMF	SURVEY PLETED
		245520	B. WING			10/2	0/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 25 WEST 31ST STREET		
REDEEN	IER RESIDENCE INC				INNEAPOLIS, MN 55408		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 050	varying conditions, The staff is familiar that drills are part of Responsibility for p assigned only to co qualified to exercise conducted betweer announcement ma alarms. 19.7.1.2 This STANDARD if Based on review of was determined that times in accordanc Section 19.7.1.2. T affect how staff real Improper reaction if of all 114 residents Findings include: On facility tour bet on 10/20/2015, a re reports in 2014 and has two shifts and the hours of 4:00 A drills were conduct PM-4:00 AM not va with Section 19.7.1	at unexpected times under at least quarterly on each shift. with procedures and is aware of established routine. lanning and conducting drills is impetent persons who are a leadership. Where drills are a 9 PM and 6 AM a coded y be used instead of audible s not met as evidenced by: of records and staff interview, it at the facility failed to vary the e with NFPA 101 LSC (00) his deficient practice could loct in the event of a fire. by staff would affect the safety ween 11:30 AM and 3:30 PM eview of the available fire drill d 2015 revealed that the facility conducted fire drills between M-8:00 PM, however no fire ed after the hours of 8:00 arying the times in accordance .2.	K	050	It is the practice of the facility that are trained and familiar with the fac- fire procedures. The facility has two shifts of staff y participate in random unannounce drills on a monthly basis which exo the Fire/safety code requirements. Fire drills were not conducted durit time noted because the facility doe wish to disturb or excite residents their sleeping hours. This practice allowable within the code Also, based on our Synchronizers Sundowners DHS PIPP grant, our to provide the optimum sleeping environment for your residents. To correct this deficiency, a calend drills will be established that will va drill times through-out the year. Compliance will be maintained thro audits and presented to the Qualit Assurance Committee. Responsible person: Maintenance	cility's who d fire seeds mg the es not during is of goal is dar of ary fire ough y	

Event ID: J1L721

Facility ID: 00160

If continuation sheet Page 4 of 6

		& MEDICAID SERVICES			0938-0391 E SURVEY
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLETED
		245520	B. WING		20/2015
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 25 WEST 31ST STREET	
REDEEM	ER RESIDENCE INC			INNEAPOLIS, MN 55408	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
		FETY CODE STANDARD	K 052 K 052		10/23/15
	installed, tested, an with NFPA 70 Natio 72. The system has	required for life safety is ad maintained in accordance anal Electrical Code and NFPA is an approved maintenance in complying with applicable iPA 70 and 72. 9.6.1.4			
e					
		27		2	, di -
	Based on docume interview, the facilit maintained in confe This deficient pract residents.	s not met as evidenced by: ntation review and staff y's fire alarm system is not ormance with NFPA 72, (99). tice could affect the 30		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	
	and 3:30 PM on 10 documentation rev	ween the hours of 11:30 AM 0/20/2015, during fire alarm iew it was revealed that the pull could not be tested and ced.		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	
K 054 SS=F	Maintenance Supe NFPA 101 LIFE SA	tice was verified by the ervisor. AFETY CODE STANDARD e detectors, including those	K 054		1/17/16

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CONTRACTOR OF

Facility ID: 00160

If continuation sheet Page 5 of 6

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES				FORM A	11/19/2015 PPROVED)938-0391 SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			BUILDING 01	COMPLE	
		245520	B. WING			10/2	0/2015
	PROVIDER OR SUPPLIER			625 V	ET ADDRESS, CITY, STATE, ZIP CODE		_
				MIND	NEAPOLIS, MN 55408 PROVIDER'S PLAN OF CORRECTIO	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE
K 054	maintained, inspec with the manufactu	age 5 sted and tested in accordance arer's specifications. 9.6.1.3 is not met as evidenced by:	К 05	54			
	Based on docume interview, the facili alarm system in ac 1999 NFPA 72, Se Findings include: On facility tour bet and 3:30 PM on 10 documentation rev south wing had 30 smoke detectors t	entation review and staff ty failed to maintain the fire coordance with the requirement actions 7-3.2 and 7-3.2.1. ween the hours of 11:30 AM D/20/2015, during fire alarm view it was revealed that the resident room hard-wired hat were obsolete in		re ut b fa A s s s T s s s	t is the facility's practice to ensure esidents and staff are provided th tmost protection and safety withir uilding and around the grounds o acility. According to federal regulations 48 moke detectors are required with xception that the building has a s ystem. The facility is totally covered by a f afety system and has a fire sprint ystem in place through-out the build the described addition was constr	e the f the 33.70 the prinkler ire kler uilding.	
	accordance with N This finding was c Supervisor at the t	onfirmed with the Maintenance	5	a T fa c c fa b w to F	The described addition was constructed addition with the Fire/Safety constructed addition with the life-safety constructed addition addition	le the le. The /e bids actor mpleted	
					тари тари тари		
FORM CMS-2	2567(02-99) Previous Version	ns Obsolete Event ID: J1L72	1	Facility	ID: 00160 If contin	uation she	et Page 6 of 6
					3 87		



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 <u>only a suggestion</u> 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, you 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

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00160	B. WING		10/1	5/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
REDEEN	IER RESIDENCE INC		31ST STRE			
			OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the	hether a violation has been compliance with all a rule provided at the tag				
	When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	ale number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
	epartment of Health / DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE
-						

Electronically Signed

6899

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00160	B. WING		10/	10/15/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
REDEEN	IER RESIDENCE INC		T 31ST STREI POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 000	Department of Hea you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th corrected prior to e Minnesota Departm On October 12th, 1 this Department's s and the following co Please indicate in y correction that you and identify the dat Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag n column entitled "IE statute/rule out of co "Summary Statemen and replaces the "T correction order. Th findings which are i after the statement evidence by." Follo	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for a indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 3th, 14th, 15th surveyors of staff, visited the above provider prection orders are issued. Your electronic plan of have reviewed these orders, e when they will be completed. The of Health is documenting to Correction Orders using ag numbers have been sota state statutes/rules for humber appears in the far left of Prefix Tag." The state compliance is listed in the ent of Deficiencies" column fo Comply" portion of the his column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and					
	FOURTH COLUM "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.					

TATEN	ta Department of He			CONSTRUCTION		
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00160	B. WING		10/	15/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
REDEEM	ER RESIDENCE INC		ST 31ST STRE POLIS, MN 55			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF ((X5)
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 265	MN Rule 4658.0085 Resident Health Sta	5 Notification of Chg in atus	2 265			11/24/15
	policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, ar attending physician development of the	st develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's e or an interested family ent's acute illness, serious At a minimum, the director of and the medical director or an must be involved in the se policies. The policies must address at least the tion times for:				
		involving the resident which has the potential for requiring on;				
	physical, mental, o example, a deterior	change in the resident's r psychosocial status, for ation in health, mental, or in either life-threatening l complications;				
	example, a need to	ter treatment significantly, for discontinue an existing form adverse consequences, or to f treatment;				
	D. a decision t resident from the nu	o transfer or discharge the ursing home; or				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00160	B. WING		10/15/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
REDEEM	IER RESIDENCE INC		T 31ST STR POLIS, MN 3			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 265		-	2 265			
	E. expected ar	id unexpected resident deaths.				
	This MN Requirem by:	ent is not met as evidenced				
	Based on interview facility failed to noti shortly after admiss	and document review, the fy a responsible party of a fall sion for 1 of 1 resident (R175) ber reported lack of		Corrected		
	Findings include:					
	10/12/15, at 1:40 p experienced a fall c only learned of the	ber (FM)-A was interviewed or .m. FM-A reported R175 had on "Friday," however, she had information when she came to ay). She confirmed she was ty for R175.				
	been admitted on 1 "frail and cachectic instructed to use th	e revealed the resident had 0/9/15 at 7:11 p.m. looking [in ill-health]." She was e call light if she needed help, the lowest position.				
	revealed R175 was the floor at around don't know what ha showed some conf injuries, bleeding, c hematoma [bruising	ted 10/9/15, at 7:38 p.m. s "found prone [face down] on 1845 [6:45 p.m.], stated, 'I ppened, I fell.' Resident usion and no agitation. No contusion, abrasion or g, scrapes, or swelling filled n head. Assisted to bed, will ghout the night."				
	10/14/15, at 3:26 p	(RN)-D was interviewed on .m. RN-D reported RN-E was tified the family of R175's fall p.m.				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED		
		00160	B. WING		10/	10/15/2015	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
REDEEM	IER RESIDENCE INC		FT 31ST STRE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 265	Continued From pa	ige 4	2 265				
		m dated 10/09/15 indicated 5's family at "2030" (8:30 p.m.).					
	10/15/15, at 10:23 arrived at the facilit approximately 10:3 her she had experie with the nurse who verified her mother When told it was do the day of the fall s	ne call was placed to FM-A on a.m. FM-A reported she y to visit R175 on 10/12/15, at 0 a.m. During her visit her told enced a fall. She then inquired was working that day, who indeed had fallen on 10/9/15. ocumented a nurse called her he emphatically replied, aid no message had been left or cell phone.					
	he stated he had co documented family verified he had not family. RN-D thoug intended to contact RN-D, the nurse m	view with RN-D at 10:30 a.m. ontacted RN-E who notification the fall. The nurse actually contacted R175's ght the nurse probably R175's family, but then forgot anager of the unit, stated he be called regarding all falls.					
	The facility's 9/11, F PolicyProtocol for licensed nurses to member/designate	Investigation of a Fall directed contact family	1				
	The director of nurs and revise policies Staff could be train to ensure responsil changes in a reside	THOD OF CORRECTION: sing or designee, could review and procedures as needed. ed. Audits could be conducted ble parties are notified of ent's health status, and the s could be brought to the or review.					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING		COM	FLETED
		00160	B. WING		10/15/2015	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
REDEEM	IER RESIDENCE INC		T 31ST STRI POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 265	Continued From pa	ige 5	2 265			
	(14) days.					
2 555	MN Rule 4658.040 Plan of Care; Deve	5 Subp. 1 Comprehensive lopment	2 555			11/24/1
	must develop a cor each resident within completion of the c assessment as defi comprehensive pla by an interdisciplina attending physician responsibility for the appropriate staff in the resident's need practicable, with the	elopment. A nursing home nprehensive plan of care for n seven days after the omprehensive resident ined in part 4658.0400. The n of care must be developed ary team that includes the , a registered nurse with e resident, and other disciplines as determined by s, and, to the extent e participation of the resident, guardian or chosen				
	by: Based on observati review the facility fa	ent is not met as evidenced ion, interview and document ailed to ensure a care plan was 3 residents (R59) reviewed for ing.		Corrected		
	Findings include:					
	to ensure the reside free. The plan lacked dependence on sta	ked direction to staff as to how ent was kept clean and odor ed identification of her ff for personal hygiene and nence care plan noted the for incontinence.				
		in her room on 10/12/15, at appeared greasy and was				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00160	B. WING	B. WING		10/15/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
REDEEN	IER RESIDENCE INC		T 31ST STRE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 555	Continued From pa	age 6	2 555				
	in the room. On 10 p.m. there was no of appearance and a On 10/14/13, at 8:3 R59, she stated the incontinent issues to well as with weekly face each day. She bathing routine. Th greasy/uncombed I following day at 8:4 still unclean and un noted. At that time not know when her	g smell of urine was detected 0/13,14, at 12:30 p.m. and 5:30 change in the resident's urine odor was present. 30 a.m. during an interview e staff helped her with her to change and clean up, as showering and washing her e was satisfied with her e resident again had hair and smelled of urine. The 5 a.m. the resident's hair was noombed and a urine odor was the resident reported she did scheduled bath day.					
	revealed the reside required extensive use, and personal I always incontinent the assessment rea during the entire per resist care during the On 10/15/15, at 9:3 (RN)-B reviewed the	himum Data Set (MDS) ent was cognitively intact, and assistance with dressing, toiled hygiene. She was noted as of urine. The bathing portion o ad, "Activity itself did not occur eriod." The resident did not he assessment period. 30 a.m. a registered nurse he care plan and verified ADLs the plan, but should have	f				
		s requested, but was not					
	The Director of Nur develop, review, ar procedures to ensu ensure appropriate	THOD OF CORRECTION: rsing or designee could nd/or revise policies and ure care plans are developed to care of residents. The or designee could educate all					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00160	B. WING	B. WING		15/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
REDEEN	IER RESIDENCE INC		ST 31ST STRE			
(X4) ID	SUMMARY STA		POLIS, MN 55	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET DATE
2 555	Continued From pa	ige 7	2 555			
		n the policies and procedures, monitoring systems to ensure e.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 840	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 2 B Adequate and re; Clean skin	2 840			11/24/1
		or determining adequate and criteria for determining er care include:				
	odors. A bathing pl resident's plan of ca condition requires t must be given a co other day and more incontinent resident every two hours, an	and freedom from offensive lan must be part of each are. A resident whose hat the resident remain in bed mplete bath at least every often as indicated. An t must be checked at least ad must receive perineal care ode of incontinence.				
	4658.0520, an inco checked according written in the reside attending physician interval longer than if competent, or a fa appointed conserva agent of a resident in writing to waive p determining this interval	1. Incontinent residents. nnesota Rules, part ntinent resident must be to a specific time interval ent's care plan. The resident's must authorize in writing any two hours unless the resident amily member or legally ator, guardian, or health care who is not competent, agrees ohysician involvement in erval, and this waiver is resident's care plan.]	· · · · · · · · · · · · · · · · · · ·			
		hing must be provided				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00160	B. WING		10/15/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
REDEEM	IER RESIDENCE INC		T 31ST STR POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 840	promptly each time Perineal care includ the perineal area. to keep the bed dry comfort. Special at skin to prevent irrita types of protectors completely covered contact with the res clothing must be re resident areas to pu This MN Requirem by: Based on observat review, the facility f services to ensure odor free for 1 of 3 dependent on staff activities of daily liv Findings include: R59 was observed 1:30 p.m. A strong the room. On 10/14 p.m. a urine odor w On 10/14/15, at 8:3 R59, she stated the incontinent issues t was satisfied with h resident again sme day at 8:45 a.m. a u	the bed or clothing is soiled. des the washing and drying of Pads or diapers must be used and for the resident's ttention must be given to the ation. Rubber, plastic, or other must be kept clean, be d, and not come in direct sident. Soiled linen and moved immediately from revent odors. ent is not met as evidenced ion, interview and document ailed to provide hygiene incontinent residents were residents (R59) who were and were reviewed for ing (ADLs). in her room on 10/12/15, at smell of urine was detected in 3,14, at 12:30 p.m. and 5:30 vas present. 0 a.m. during an interview e staff helped her with her to change and clean up. She her bathing routine. The lled of urine. The following urine odor was noted. imum Data Set (MDS)	2 840	Corrected		
		nt was cognitively intact, and assistance bathing and toilet				

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED	
		00160	B. WING	B. WING		15/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	ADDRESS, CITY, STATE, ZIP CODE				
REDEEM	IER RESIDENCE INC		T 31ST STREE				
			POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 840	Continued From pa	ge 9	2 840				
	use. She was noted urine. The resident	as always incontinent of did not resist care.					
	to how to ensure th	59 lacked direction to staff as e resident was kept odor free. re plan noted the resident was nce.					
	(RN)-B reported sh of urine. She said t	0 a.m. a registered nurse e was unaware R59 smelled the staff was responsible for assisted with incontinence n good hygiene.					
	A related policy was provided.	s requested, but was not					
	The director of nurs review/revise policie ensure dignified ca to residents who do own ADL care indep be re-educated on the A system for evalua- implementation of the developed, with the	HOD OF CORRECTION: sing or designee, could es and procedures related to the and services are provided on thave the ability to do their bendently. Employees could these policies and procedures. ating and monitoring consistent hese policies could be results of these audits being ty's quality committee for					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
2 845	MN Rule 4658.0520 Proper Nursing Car) Subp. 2 C Adequate and re; Shampoo	2 845			11/24/15	
		r determining adequate and riteria for determining er care include:					

	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING	:		
		00160	B. WING		10/15/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
REDEEN	IER RESIDENCE INC		T 31ST STR			
			POLIS, MN 5	PROVIDER'S PLAN OF CORRECTI		(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLET DATE
2 845	Continued From pa	age 10	2 845			
		oo at least weekly and Iy hair grooming as needed.				
	This MN Requirem by:	ent is not met as evidenced				
	review, the facility f services to ensure combed for 1 of 3 r	ion, interview and document failed to provide hygiene residents hair was clean and residents (R59) who were and were reviewed for ring (ADLs).		Corrected		
	Findings include:					
	1:30 p.m. Her was uncombed. On 10/	in her room on 10/12/15, at appeared greasy and was 13,14, at 12:30 p.m. and 5:30 change in the resident's				
	R59, she stated the weekly showering a day. She was satis The resident again The following day a was still unclean ar	30 a.m. during an interview e staff helped her with her with and washing her face each sfied with her bathing routine. had greasy/uncombed hair. at 8:45 a.m. the resident's hair nd uncombed. At that time the he did not know when her y.				
	revealed the reside required extensive hygiene. The bathin read, "Activity itself	nimum Data Set (MDS) ent was cognitively intact, and assistance with personal ng portion of the assessment did not occur during the entire ent did not resist care.				
	to how to ensure th odor free. The plan	R59 lacked direction to staff as the resident was kept clean and a lacked identification of her				
inesota D ATE FORI	epartment of Health M		6899	J1L711	If continuatio	n sheet 11 c

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00160	B. WING		10/	15/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
REDEEN	IER RESIDENCE INC		ST 31ST STRE POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 845	Continued From pa	ge 11	2 845			
	dependence on sta bathing.	ff for personal hygiene and				
	(RN)-B reported sh was unclean and u	0 a.m. a registered nurse e was unaware R59 her hair ncombed. She said the staff rensuring R59 was assisted od hygiene.				
	A related policy was provided.	s requested, but was not				
	The director of nurs review/revise policie ensure dignified ca to residents who do own ADL care indep be re-educated on A system for evaluation implementation of t developed, with the	THOD OF CORRECTION: sing or designee, could es and procedures related to are and services are provided o not have the ability to do their bendently. Employees could these policies and procedures ating and monitoring consisten hese policies could be results of these audits being ty's quality committee for				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 960	MN Rule 4658.060 Food Quality	0 Subp. 1 Dietary Service -	2 960			11/24/15
		uality. Food must have taste, ance that encourages resident d.	t			
	by:	ent is not met as evidenced				
	Based on observati	on, interview and document		Corrected		

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00160	B. WING		10 / ⁻	15/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
REDEEN	IER RESIDENCE INC		T 31ST STRE			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 960	Continued From pa	lge 12	2 960			
	served at palatable resident (R160) wh	ailed to ensure food was temperatures for 1 of 1 o requested food reheated other 14 residents in the 2W				
	Findings include:					
	dietary aide (DA)-A two metal food war covered with foil, bu plugged in the food partially leaving the maximum temperat covers were remov taken of the individu temperatures, how metal probe touches stated it was the wa temperatures with t pan. The corn regis (F), and chicken no registered 140 degi foods should have they did not he hea asked for food to bu					
	of food from the tak room to re-heat her place between DA- how long the food r) stood up and took her plate ble to the microwave in the r food. A discussion then took A and a nursing assistant as to needed to be microwaved. A ssisted the resident to reheat				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00160	B. WING		10/15/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
	IER RESIDENCE INC	625 WES	ST 31ST STRE	ET		
		MINNEA	POLIS, MN 55	408		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 960	Continued From pa	age 13	2 960			
	potatoes, and mixe the microwave for t to R160. A second with foil was hand of The riblets register proceeded to indivis served of riblets, po or corn to the rest of yet been served in the warmers was led dining service. At 1 the food warmers r mixed vegetables r temperatures were the dining director (pan of pork riblets s the kitchen at 170 of informed the DD th degrees after arriva stated she did not k been immediately of a delay due to the e an announcement l loudspeaker to kee mealtime.	reheat R160's pork riblets, id vegetables a second time in two minutes before reserving pan of pork riblets covered carried up from the kitchen. ed 130 degrees, and DA-A dually microwave each plate batoes and mixed vegetables of the residents who had not the dining room. The food in eft uncovered throughout the 2:25 p.m. mashed potatoes in egistered 120 degrees and egistered 130 degrees when re-taken. Five minutes later (DD) reported that the second sent to replace the first pan left degrees. The surveyor then at the riblets measured 130 al when DA-A measured it. DE know whether the riblets had delivered, or whether there was elevators being busy. She said had been made over the up the elevators free during	t 5			
	"My food is frequen my food up in the m guess it is somethin do your self." R160 "right away" and sa	at 11:41 a.m. R160 reported, htly coolnot hot enough. I hean nicrowave quite oftenSo I ng you have to put up with and stated she usually was served hid she was glad the surveyor the food was not being served	k			
	a food cart with two	t 12:06 p.m. DA-C brought up o metal warmers placed on the lgs. DA-C then plugged in the eded to measure the				

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE 2 960 Continued From page 14 2 960 <	STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
REDEEMER RESIDENCE INIT Base of the state of the s			00160	B. WING		10/15/2015	
HEDELMER HESIDENCE INC MINNEAPOLIS, MN 55408 (M) ID PREFIX TAG ISUMMARY STATEMENT OF DEFICIENCIES REGULTATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOLD BE CAROSS REFERENCED TO THE APPROPMARE 0(95) COMPLEX PREFIX 2 960 Continued From page 14 2 960 2 960 temperatures of the food. A click was again heard as the probe touched the bottom of the metal pan when the meatloal temperature was measured. DA-C pulled the foil back from the individual pans and did not partially or re-over the food. 2 960 Hamburger registered 120 degrees. In surveyor reviewed the temperatures after DA-C had recorded the temperatures and toods' column. When asked why the temperatures were recorded as they were, DA-C replied the food souther. When asked why the temperatures being lower than a 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 yestered, I're-toil the staff in morning meeting today to put plastic covers on the warmers" during transport, and to keep the food. Since we talked yestereday. I're-toil 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, bit 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 Wolrath (brand name) manufacturer's instructions. <th>NAME OF F</th> <th>ROVIDER OR SUPPLIER</th> <th>STREET AL</th> <th>DRESS, CITY, S</th> <th>TATE, ZIP CODE</th> <th></th> <th></th>	NAME OF F	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
IMID MERCY TAG SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY WINTS DE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) ID PREVIDE TAG DROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) ID PREVIDE PREVIDE TAG DROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY) UD DEFICIENCY 2 960 Continued From page 14 2 960 2 960 2 960 DEFICIENCY) DEFICIENCY DEFICIENCY 2 961 temperatures of the food. A click was again heard as the probe touched the bottom of the metal pan when the meatlact temperature was measured. DA-C pulled the foil back from the individual pans and did not partially or re-over the food. 2 960 Hamburger registered 120 degrees. The surveyor reviewed the temperatures agter DA-C had recorded the temperatures and code's columns different from that foods' column. When asked why the temperatures were recorded as they were, DA-C replied, 'I sometimes wite the temperature anymere as there is no place for it on the log'. DA-C also stated only 2W and 3W diving rooms used warmers to transport and serve the food, as the other dining rooms had kitchenetts, When asked about the hamburger and chicken legs temperatures being lower than the policy directed, JA-C capialed that she would have warmers the tood covered during it meals partice. Since we talked yesterctay, I re-told the staff in morning meeting today to put plastic covers on the warmers'' during it meals exircle. The was unsure why when all staff had been trained, that the coverse were not in use in the 2W dining room, bat she would continue to monitor the situation. The change from steam tables in the two dining areas to the use of the warmers had	REDEEM	ER RESIDENCE INC					
PRÉETX TAG (EACH OBEFICIENCY MUST BE PRECEDED BY FULL REQUATORY OR LSC IDENTIFYING INFORMATION) PRÉEX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLE DEFICIENCY) 2 960 Continued From page 14 2 960 2 960 2 960 2 960 DEFICIENCY) DEFICIENCY DEFICIENCY) DEFICIENCY DEFICIENCY) DEFICIENCY DEF		SUMMARY STA		-		CORRECTION	(XE)
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 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 temperatures as 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, 1 re-told the staff in morning meeting tody to put platic covers on the warmers" during the meal service. She was unsure why were not in use in the 2W dining room, but she would continue to monitor the situation. The 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 Volirath (brand name) manufacturer's instructions.	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	FION SHOULD BE THE APPROPRIATE	COMPLET DATE
 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 123 degrees, chicken legs registered 123 degrees and chicken noodle soup registered 123 degrees. The surveyor reviewed the temperatures after DA-C had recorded 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. 	2 960	Continued From pa	age 14	2 960			
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.		when the meatloaf DA-C pulled the foi and did not partially Hamburger register registered 123 deg registered 140 deg the temperatures a temperatures on a however, were writt different from that f why the temperatur were, DA-C replied temperature anywh on the log." DA-C a dining rooms used serve the food, as t kitchenettes. When and chicken legs te the policy directed, would have warmed request.	temperature was measured. I back from the individual pans y or re-cover the food. red 120 degrees, chicken legs rees and chicken noodle soup rees. The surveyor reviewed fter DA-C had recorded the log. The temperatures, ten on different columns foods' column. When asked res were recorded as they I, "I sometimes write the here as there is no place for it also stated only 2W and 3W warmers to transport and the other dining rooms had n asked about the hamburger emperatures being lower than DA-C explained that she d the food per resident				
On 10/14/15, at 8:41 a.m. plastic covers were		yesterday, I re-told today to put plastic during transport, ar during the meal ser when all staff had b were not in use in t would continue to n change from steam to the use of the wa ago, and they had r Vollrath (brand nam instructions.	the staff in morning meeting covers on the warmers" and to keep the food covered rvice. She was unsure why been trained, that the covers he 2W dining room, but she nonitor the situation. The in tables in the two dining areas armers had started just a year not maintained the Cayenne he) manufacturer's				

	NT OF DEFICIENCIES I OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00160	B. WING		10/	15/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
REDEEN	IER RESIDENCE INC		T 31ST STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 960	Continued From pa	age 15	2 960			
	on the warmers, bu differently" with sort the food with foil. If been taught by the covers. In addition ensure the metal p metal pan when tak the entire food was whether measuring bottom of the pan w affect the temperat At the noon meal th the 2W dining room observed being trai covers off the pans inches, as there we pans stacked, thus fitting snuggly. Three stacked on lower p with the hot water i DA-B plugged in th temperatures. Chick degrees and tomat degrees. When asis DA-B stated, "110 of After the meal DD stouch the bottom of verified the metal p directly in contact w warmer. Policies regarding f was requested but SUGGESTED MET The dietitian and for ensure policies and	ways used the plastic covers at that dietary staff "work me dietary staff just covering DA-B also reported she had DD to utilize the plastic , they were supposed to robe touched the bottom of the king temperatures, to ensure a warm. DA-B was unsure the metal probe touching the would potentially erroneously ure of the food. That same day at 12:01 p.m. in n, food warmers were msported with the plastic as much as four to five ere multiple different shaped preventing the covers from ee of the eight pans were ans and were not in contact intended to keep the food hot. e warmers and measured food sken soup registered 112 o soup registered 118 ked about the temperatures degrees is okay for soup." stated she had trained staff to f the pan with the probe. DD pans should have all been with the hot water in the food temperatures and serving not provided by the facility.				

	ta Department of He	alth			F	I APPROVEI
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED
		00160	B. WING		10/15/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
REDEEN	IER RESIDENCE INC		T 31ST STR			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	N SHOULD BE	(X5) COMPLETE DATE
TAG			TAG	DEFICIENCY)		
2 960	Continued From pa	lge 16	2 960			
	be trained. Audits of conducted and resi satisfaction. The re brought to the quali	tures. Appropriate staff could of food temperatures could be dents randomly interviewed for esults of the audits could be ity committee for review.				
01375	(14) days.	0 Subp. 1 Infection Control;	21375			11/24/15
21373	Program	o Subp. T intection Control,	21375			11/24/15
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				
	by: Based on observati review the facility fa procedures were fo spread of infection observed blood glu affecting a second was also utilized. In administered in a s	ent is not met as evidenced ion, interview and document ailed to ensure infection control ollowed to minimize the risk for for 1 of 1 resident (R57) cose test and additionally resident for whom the device addition, medication was not anitary manner for 1 of of 5 ose medication administration		Corrected		
	Findings include:					
	11:56 a.m. by a reg the check was com Wipe germicidal clo 3-4 seconds, and th	was checked on 10/14/15, at istered nurse (RN)-A. After pleted, RN-A used a Sani oth to clean the glucometer for nen set the glucometer on top art. RN-A was asked if this				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00160	B. WING		10/15/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
REDEEN	IER RESIDENCE INC		ST 31ST STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 17	21375			
	RN-A said it was he glucometer for five RN-A also reported the current time by recently "audited" h how she cleaned th auditing process. At 1:05 p.m. a licen reported she wiped with the Sani Wipe Wipe around the gl The surveyor then	ner for cleaning glucometers. er usual practice to wipe the seconds before and after use. I the glucometer was used at two residents. The facility had her on this, and stated it was he glucometer during the used practical nurse (LPN)-B the entire glucometer all over , and then wrapped the Sani ucometer for three seconds. clarified with LPN-B if she e seconds and LPN-B again nds."				
	to clean glucomete the manufacturer's referred to the instr container and read glucometers should	r, RN-B explained nurses were rs after each use "according to instructions." RN-B then uctions on the Sani Wipe , "two minutes." RN-B said d have remained wet by around the glucometer and inutes.				
	at the facility. She s wiped "real good" a unsure how long th	reported being recently hired stated glucometers should be and left to air dry. RN-C was e glucometer should be wiped w long it needed to be air dried ther resident.				
	by RN-A on 10/14/ ⁻ washing her hands the tablet with her b the usual method s and she was unsur	nin D3 tablet was administered 15, at 8:35 a.m. Without or using alcohol gel, RN-A cut pare hands. RN-A said it was he used to break the tablets, e how to break the medication hing it. The rationale for				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00160	B. WING		10/	15/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
REDEEN	IER RESIDENCE INC		T 31ST STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 18	21375			
	breaking the tablet R66 to swallow.	was that it was "easier" for				
	(DON) was intervie have followed man sanitizing the gluco audits to ensure co with nurses. The D	rvation, the director of nursing wed, and said nurses should ufacture's instructions for ometers, and verified related ompliance had been conducted ON further explained it was yould not touch a resident's bir hands.				
	policy directed staff maintain cleanlines (glucometer) and p with blood-borne paresident useDisin a. Remove the EPA Agency] approved container. b. Wipe battery compartme strip port. c. Allow t (glucometer) to cor manufacturer's dire [minimize the risk of	lucose Meter Disinfection f as follows: "Purpose: To as of blood glucose meter revent cross-contamination athogens between each affect the blood glucose meter: A [Environmental Protection disinfectant wipe from the meter down, avoiding the nt, code ship port, and the test the Blood Glucose Meter mpletely dry (according to bections to mitigate HIV of Human Immunodeficiency s and bacteria) before doing ose check."				
	Guidelines policy n necessary to admir must be washed w	ion Administration: General oted, "If breaking tablets is hister the proper dose, hands ith soap and water or alcohol er, and gloves used prior to				
	The director of nurs	THOD OF CORRECTION: sing and infection control nurse es and procedures are sed nurses could be trained.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (2	X3) DATE SURVEY COMPLETED	
		00160	B. WING		10/15/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
REDEEM	IER RESIDENCE INC		T 31ST STR POLIS, MN 3			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPL	
21375	Continued From pa	age 19	21375			
		nducted and the results ity committee for review.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21565	MN Rule 4658.132 Medications Self Ad	5 Subp. 4 Administration of dmin	21565		11/24/	
	self-administer med resident assessme care as required in 4658.0405 indicate	ninistration. A resident may dications if the comprehensive nt and comprehensive plan of parts 4658.0400 and this practice is safe and there om the attending physician.				
	by: Based on observat review, the facility f self-administration	of medications was a safe esident (R132) observed with		Corrected		
	Findings include:					
	while sitting in a red resident was whimp containing five pills her, and another pi	d on 10/15/15, at 1:29 p.m. cliner in her room. The pering. A medicine cup was on the footrest in front of Il was outside the cup on the ified the pills were hers, and n.				
	of nursing (DON) a verified R132 was of topical medications	ediately summoned the director nd a registered nurse. RN-D only allowed to self-administer c. RN-D then discovered R132 g the medications, but said the				

Minnesc	ta Department of He	alth			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
				·		
		00160	B. WING		10/1	5/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
REDEEN	IER RESIDENCE INC		OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21565	Continued From pa	ge 20	21565			
	nurse should not ha medications.	ave left R132 with the				
	resident was capab medication that was self-administration. 5/5/15, indicated a Medication assess prior to allowing the medications. The ca however, self-admin A 1/13, Medication- indicated "All medic by facility staff until has been assessed from the physician f administer and the SUGGESTED MET The director of nurs ensure all residents medications are ass do so. Staff respon could be conducted	ation of Medication 32 dated 5/5/15, revealed the le of administering a topical s left in her room for R132's care plan dated Self-Administration of nent was to be completed resident to self-administrate are plan noted R132 could, nister the topical medication. Self Administration policy sations must be administered their ability to self administer . Staff must obtain an order for a resident to self care plan is to be updated." THOD OF CORRECTION: sing (DON) or desigee could who wish to self-administer sessed and deemed safe to isible could be trained. Audits to ensure compliance and the ne quality committee for				
	review. TIME PERIOD FOF (14) days.	R CORRECTION: Fourteen				
21990	MN St. Statute 626. Maltreatment of Vul	557 Subd. 4 Reporting - nerable Adults	21990			11/24/15
	immediately make a	g. A mandated reporter shall an oral report to the common				
Minnesota D STATE FOR	epartment of Health M		6899	J1L711	If continuatio	n sheet 21 of 27

	00160				
		B. WING		10/15/2015	
IAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
REDEEMER RESIDENCE INC		31ST STRE OLIS, MN 5			
(X4) ID SUMMARY STATE			PROVIDER'S PLAN OF CORRECTIC	N (X5)	
PREFIX (EACH DEFICIENCY M	UST BE PRECEDED BY FULL DENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPL	
21990 Continued From page	e 21	21990			
for the deaf or other s considered an oral re point may not require extent possible, the re content to identify the caregiver, the nature maltreatment, any evi maltreatment, the nar reporter, the time, dat incident, and any othe reporter believes mig the suspected maltreat reporter believes mig the suspected maltreat reporter may disclose in section 13.02, and section 144.335, to th comply with this subd This MN Requirement by: Based on interview and facility failed to immed administrator and des and to thoroughly inve 2 residents (R174, R4 abuse by a staff person Findings include: R174 reported he was respect by a nursing a interview on 10/13/15 physically described to incident happened the morning cares. The re "poor attitudeWhen diapers she made a co	me and address of the te, and location of the er information that the ht be helpful in investigating atment. A mandated e not public data, as defined medical records under ne extent necessary to livision. It is not met as evidenced and document review, the diately report to the signated State agency (SA) estigate an allegation for 1 of 48) who alleged verbal		Corrected		

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00160	B. WING		10/15/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	IER RESIDENCE INC	625 WES ⁻	T 31ST STRE	ET		
NEDEEN		MINNEAP	OLIS, MN 55	5408		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21990	Continued From pa	ge 22	21990			
	had told him to covi added, "He probabli should be checked had made other de and had been indiff he had not reported feel smallI didn't r cannot talk to ignor During a second co 12:50 p.m. R174 st to the social worker felt he had been ab An interview with a on 10/15/15, at 8:10 told her first on 10/1 during their initial vi did not like the way did not consider this explained R174 sp regarding his treath felt he was verbally stated she brought corporate represen reportable incident. initiated at this time At 8:33 a.m. the sat interviewed. NA-B morning rounds NA providing care for I assisting R174, N. brief and asked the yucky white stuff in	onversation on 10/14/15, at ated he reported the incident r earlier that day because he bused verbally by NA-A. licensed social worker (LSW) 6 a.m., revealed R174 had 12/15 regarding the incident sit. The LSW stated R174 the NA-A made him feel but s to be abuse. She further boke to her again on 10/14/15 nent and this time stated he abused by NA-A. The LSW it to the attention of the tative and was told it was not a An investigation was not				
	stated "He was so l	or protection. NA-A then bad this morning, he was like				
	an asshole" (becau	se he was anxious and kept				

STATEMEN	DIT DEPARTMENT OF HE NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00160	B. WING		10/15/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
REDEEN	IER RESIDENCE INC		ST 31ST STRE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21990	Continued From parturning on his light) these statements in and portrayed this t stated she had report At 8:49 a.m. R174 st the abuse on Mond abuse but later he of as abuse and state insignificant." At 8:59 a.m. while of director of nursing (was reporting at that she would have exp abuse to be reported should have been r policy." At approximately 9: RN-F was not in the phone. She did not incident. Later that day at 100 spoke with the corp verified the LSW hat attention, but did not incident. R174 was newly ad diagnoses including Mental Status score intact cognition (15,	ge 23 . She added NA-A had made the presence of the resident, ype of demeanor often. NA-B orted the situation to RN-F. stated when he first reported ay he did not consider it as did. He reported it to the LSW d it made him "feel explaining the incident the (DON) she verified the LSW at time. She further explained bected an incident of reported ed to the SA immediately. "This eported yesterday. It is our 32 a.m., RN-D explained e facility but spoke to her by recall NA-B reporting the c:02 a.m. the DON stated she borate representative and ad brought the allegation to her but feel it was a reportable mitted to the facility with g anxiety. A Brief interview for e dated 10/12/15, revealed (15 possible). otes were reviewed but lacked	21990			
	A request for all inc requested but was epartment of Health	ident reports for R174 was not provided.				

STATE FORM

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00160 00160		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00160	B. WING		10/15/2015		
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	ADDRESS, CITY, STATE, ZIP CODE				
REDEEN	IER RESIDENCE INC		T 31ST STRE POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21990	Continued From pa	age 24	21990				
	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 person knowledge of the in The report did not i the report was not following day, nor n	s to determine their potential noident or similar allegations. nclude a rationale as to why made by NA-Y until the neasures taken to ensure nediately in the future.					
	revealed the reside memory problems staff assistance for	ta Set (MDS) dated 8/12/15, ent had short and long term and required staff extensive cares such as bed mobility, dressing, toileting, and					
	(DON) reported NA reporting because to the end of her shift. have expected aller reported. Although about immediate re- documented the co- explained a previou investigation into R	27 p.m. the director of nursing -Y may have delayed the incident did not occur until . The DON reported she would gations to be immediately she had spoken to NA-Y eporting, she had not onversation. The DON us manager had completed the 48's allegation, and believed s had been interviewed, but					
	again, had not been verified other reside and staff persons s	n documented. The DON ents or their family members hould have been interviewed dge of how residents were					

			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
00160		B. WING		10/15/2015		
OVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
R RESIDENCE INC						
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREEIX			(X5) COMPLE	
		TAG	CROSS-REFERENCED TO TI	HE APPROPRIATE	DATE	
Continued From pa	ige 25	21990				
imilar allegations. eview NA-Y's emp eporting of allegati ther investigative i elated to R48. The facility's 9/13, N Prohibition Plan dire esponsible to repo f mistreatment, ne and/or misappropria mediately to one Supervisor, Nurse of Social Worker. The mediately to one adjuster all alleged v neidents immediate uspicious bruising watterns and trends and determine the nesident abuse, neg inknown source ar esident property shoroughly investiga- toroughly investiga- noroughly investiga- novestigation may in- hysical examination- environment. Exam- censed nurse or p	The DON reported she would loyee file regarding immediate ons and check to see if any information was available Vulnerable Adult Abuse ected staff: "Each employee is rt suspected/alleged violations eglect, and abuse of residents ation of resident property of the following: Nursing on Duty, Director of Nursing or e administrator will be notified e of the above. Staff may go Administrator if desired. riolations and substantiated ely to the SA and all other edIdentify events, such as of residents, occurrences, s that may constitute abuse direction of the I reports of suspected/alleged glect, mistreatment, injuries of nd/or misappropriation of nall be promptly and ated. 2. Collect data and ative findings. 3. The nclude but is not limited to: on of the resident and nination of the resident by a hysician. IF sexual abuse is					
lothing or linen. Do which the incider locumentation and	o not take items from the area nt occurred. Review					
	R RESIDENCE INC SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From para reing treated and/or imilar allegations. eview NA-Y's emp eporting of allegations. eview NA-Y's emp eporting of allegations. eview NA-Y's emp eporting of allegations. Prohibition Plan dir esponsible to report f mistreatment, ne and/or misappropri mediately to one Social Worker. The mediately to one Social Worker. The mediately to one supervisor, Nurse of action and trends and determine the suppicious bruising patterns and trends and determine the nvestigation1. Allesident abuse, neg inknown source ar esident property sil- horoughly investigation may in hysical examination environment. Exam- censed nurse or po- uspected, call the athe/wash the res- lothing or linen. Do n which the incider locumentation and	R RESIDENCE INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 25 leing treated and/or their knowledge of potential imilar allegations. The DON reported she would eview NA-Y's employee file regarding immediate eporting of allegations and check to see if any ther investigative information was available elated to R48. The facility's 9/13, Vulnerable Adult Abuse Prohibition Plan directed staff: "Each employee is esponsible to report suspected/alleged violations of mistreatment, neglect, and abuse of residents ind/or misappropriation of resident property mmediately to one of the following: Nursing Supervisor, Nurse on Duty, Director of Nursing or Social Worker. The administrator will be notified nmediately by one of the above. Staff may go inmediately to the Administrator if desired. Report all alleged violations and substantiated notidents immediately to the SA and all other gencies as requiredIdentify events, such as uspicious bruising of residents, occurrences, atterns and trends that may constitute abuse ind determine the direction of the nestigation1. All reports of suspected/alleged esident abuse, neglect, mistreatment, injuries of inknown source and/or misappropriation of esident property shall be promptly and noroughly investigated. 2. Collect data and locument investigative findings. 3. The nyestigation may include but is not limited to: hysical examination of the resident and invironment. Examination of the resident by a censed nurse or physician. IF sexual abuse is uspected, call the police immediately. DO NOT athe/wash the resident or wash the resident's lothing or linen. Do not take items from the area in which the incident occurred. Review locumentation and the resident's medial record	RESIDENCE INC 625 WEST 31ST STREE MINNEAPOLIS, MN 55 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 25 21990 eing treated and/or their knowledge of potential imilar allegations. The DON reported she would eview NA-Y's employee file regarding immediate eporting of allegations and check to see if any ther investigative information was available elated to R48. 21990 The facility's 9/13, Vulnerable Adult Abuse Prohibition Plan directed staff: "Each employee is esponsible to report suspected/alleged violations f mistreatment, neglect, and abuse of residents ind/or misappropriation of resident property numediately to one of the following: Nursing Supervisor, Nurse on Duty, Director of Nursing or locial Worker. The administrator will be notified numediately to the Administrator if desired. Report all alleged violations and substantiated necidents immediately to the SA and all other gencies as requiredIdentify events, such as uspicious bruising of residents, occurrences, atterms and trends that may constitute abuse ind determine the direction of the novestigation1. All reports of suspected/alleged esident abuse, neglect, mistreatment, injuries of inknown source and/or misappropriation of the resident by a censed nurse or physician. IF sexual abuse is uspected, call the police immediately. DO NOT athe/wash the resident or wash the resident's lothing or linen. Do not take items from the area in which the incident occurred. Review locumentation and the resident's medial record	RESIDENCE INC 625 WEST 31ST STREET MINNEAPOLIS, MN 55408 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MS THE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PREVIDER'S PLAN OF OC CROSS-REFERENCED TO THE DEFICIENCY TAG PREFIX (EACH CORRECTIVE ACT CROSS-REFERENCED TO THE DEFICIENCY Continued From page 25 21990 21990 eing treated and/or their knowledge of potential imilar allegations. The DON reported she would eview NA-Y's employee file regarding immediate eporting of allegations and check to see if any ther investigative information was available elated to R48. 21990 The facility's 9/13, Vulnerable Adult Abuse robibition Plan directed staff: "Each employee is esponsible to report suspected/alleged violations if mistreatment, neglect, and abuse of residents nmediately to one of the following: Nursing typervisor, Nurse on Duty, Director of Nursing or social Worker. The administrator will be notified mmediately to the Administrator will be notified mediately to the Administrator if desired. Report all alleged violations and substantiated recidents immediately to the SA and all other gencies as requiredIdentify events, such as uspicious bruising of residents, occurrences, atterns and trends that may constitute abuse ind determine the direction of the rvestigation1. All reports of suspected/alleged esident abuse, neglect, mistreatment, injuries of inknown source and/or misappropriation of esident property shall be promptly and noroughly investigated. 2. Collect data and occument. Examination of the resident's lothing or linen. Do not take items from the area invhich the incident occurred. Review occumentation and the resident's lothing or linen. Do not take items from the area in	RESIDENCE INC 625 WEST 31ST STREET MINREAPOLIS, MN 55408 SUMMARY STATEMENT OF DEFICENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PRETRX TAG PROVIDENS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRECENT OF LSC IDENTIFYING INFORMATION) Continued From page 25 21990 Imitar allegations. The DON reported she would eview NA-Y's employee file regarding immediate porting of allegations and check to see if any ther investigative information was available elated to R48. 21990 The facility's 9/13, Vulnerable Adult Abuse trohibition Plan directed staff: "Each employee is seponsible to report suspected/alleged violations f mistreatment, neglect, and abuse of residents nd/or misappropriation of resident property mmediately to one of the following: Nursing supervisor, Nurse on Duty, Director of Nursing or social Worker. 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Minnesota Department of He STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00160	B. WING		10/	15/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
REDEEM	IER RESIDENCE INC		ST 31ST STREI POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21990	the incident. Intervie Interview other resi perpetrator provide completed docume SUGGESTED MET The director of nurs review, revise, deve and procedures to a are reported immed audits could be com provided to ensure and reported correct to the quality comm	rview any potential witness to ew the alleged perpetrator. dents to whom the alleged s care or services. Review the ntation." THOD OF CORRECTION: sing (DON) or designee could elop and implement policies ensure allegations of abuse diately. In addition random inducted and staff training all allegations are investigated ctly. Audits could be brought				