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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KXYW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00993

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/08/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
__X__ 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Supervisor 07/08/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 07/08/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/26/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: July 11, 2014

CMS Certification Number (CCN): 24-E116

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

Dear Mrs. Foy:

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

Based upon your facility being in substantial compliance, we are recommending to the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective June 17, 2014 the above facility is certified for:

212 - Nursing Facility II Beds

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

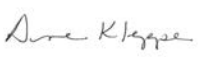
If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicaid Program.

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 Medicaid provider agreement may be subject to non-renewal or termination.

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

Sincerely,



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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: July 8, 2014

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

RE: Project Number SE116023

Dear Mrs. Foy:

On May 28, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 20, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On July 8, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 20, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 17, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 20, 2014, effective June 17, 2014 and therefore remedies outlined in our letter to you dated May 28, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Feel free to contact me if you have questions about this electronic notice.

Sincerely,

Anne Kleppe

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E116	A. Building B. Wing	7/8/2014

Name of Facility	Street Address, City, State, Zip Code
ANDREW RESIDENCE	1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **06/17/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **06/17/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **06/17/2014**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **06/17/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	07/08/2014	18623	07/08/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/20/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KXYW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00993

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/20/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE NE II 06/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 06/25/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
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28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24-E116

At the time of the standard survey completed 05/20/14, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit (PCR) to follow.

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: KXYW

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/20/2014** (L34)

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02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
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FISCAL YEAR ENDING DATE: (L35)
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From (a) :
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__1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
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__3. 24 Hour RN __7. Medical Director
__4. 7-Day RN (Rural SNF) __8. Patient Room Size
__5. Life Safety Code __9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Magdalene Jares, HFE NE II — 06/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Anne Kleppe, Enforcement Specialist — 06/25/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
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24. LTC AGREEMENT ENDING DATE
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25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
6-26-14 (L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions)

020499

CCN: 24-E116

At the time of the standard survey completed 05/20/14, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit (PCR) to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: May 28, 2014

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

RE: Project Number SE116023

Dear Mrs. Foy:

On May 20, 2014, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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>Electronic 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:

Gloria Derfus, Supervisor
Metro C Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 29, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated

in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 20, 2014 (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 November 20, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

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

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E116	A. BUILDING _____ B. WING _____	05/20/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to make the state survey results available for examination in a place readily accessible to residents or post a notice of their availability. This had the potential to affect all 211 residents, staff and visitors at the facility.	F 167	It is the practice of Andrew Residence to make available to residents, visitors and other interested persons the survey results. A policy has been developed and all receptions have been educated on survey result accessibility. Survey results will be made further accessible by	6/17/14

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

Electronically Signed | 06/04/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E116	A. BUILDING _____ B. WING _____	05/20/2014

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F 167	Continued From page 1 Findings include: During the initial tour on 5/18/14, at 7:15 a.m. a binder with previous survey results was observed stored upright, the first row of binders on a shelf positioned to the left of the receptionist desk. The results were only viewable by standing directly in front of the desk and would not be viewable to a person in a wheelchair. Observations on 5/18/14, at 7:15 and 3:31 p.m. 5/19/14, at 10:30 a.m. and 5/20/14, at 7:32 a.m. observed the binder to remain behind the receptionist desk. When interviewed on 5/20/14, at 11:33 a.m. the receptionist supervisor (RS) stated sometimes the results were up on the counter but for the past couple of years they have been behind the desk. RS stated she would hand someone the binder if they would ask for them and when asked how someone in a wheelchair would be able to see or have access to the results, RS stated "that's a good point". When interviewed on 5/20/14, at 11:43 a.m. the director of nursing services (DNS) stated she was accustomed to the results being on the desk and did not know they were not there all week. DNS stated "I would have expected the results to be accessible to anyone who asked to see them, they could go behind the desk to see them, and nothing happened or was discussed to have to put the results back there." When interviewed on 5/20/14, at 3:01 p.m. DNS stated there was no written policy for posting of survey results, "It is just expected they be accessible to anyone due to being a regulation."	F 167	displaying them in a easily accessible location. The Director of Program Services or designee will monitor their accessibility and report results to the quality assurance committee.	
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		6/12/14

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F 329 SS=D	Continued From page 2 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to monitor for adverse side effects for 1 of 5 residents (R136) who received antipsychotic medications. Findings include: R136's Physician Orders dated 5/7/10 and 4/29/14, indicated R136 received antipsychotic's	F 329	It is the practice of Andrew Residence to conduct in conjunction with the psychiatrist twice annual DISCUS assessments. DISCUS assessment was done the day it was identified. A review of all facilities DISCUS assessments was completed to ensure their timely completion. The DON or designee will conduct a review of DISCUS	

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F 329	Continued From page 3 Risperdal 3 Milligrams (mg) by mouth (PO) at bedtime (HS) for schizophrenia and Seroquel 250 mg PO every bedtime for Paranoid Schizophrenia respectively. Additionally, a Physician's Order dated 1/17/07, indicated R136 received Cogentin 1 mg PO at HS (Medication used for treatment of extrapyramidal symptoms caused by antipsychotic medications and Parkinson's disease) R136's annual Minimum Data Set (MDS) dated 3/29/14, indicated R136's diagnoses included schizophrenia, unspecified extrapyramidal disease, abnormal movement disorder and insomnia. In addition the MDS indicated R136 received antipsychotic's seven days a week, had hallucinations and other behavioral symptoms not directed towards others. Care Area Assessment (CAA) dated 3/29/14, indicated R136 had persistent mental illness was prescribed the medications Seroquel and Risperdal. The CAA directed medication side effect monitoring to be done bi-annually using the MOSES (Monitoring Of Side Effects Scale) and DISCUS tools and in addition medications were reviewed every three months with his psychiatrist and consulting pharmacist. R136's Annual Treatment Plan Review dated 4/10/14, indicated R136 had symptoms of mental illness which included auditory hallucinations, aggressive behavior towards people and withdrawal/isolation. Goal "Will learn to manage symptoms of mental illness and learn about schizophrenia..." Plan indicated R136 was expected to "Meet with [Program Manager] to discuss symptoms, side effects, and coping skills weekly."	F 329	assessments on a quarterly basis to ensure their timely completion going forward. If the psychiatrist does not complete the assessment within the scheduled time frame qualified Andrew staff will complete the assessment. The results of DISCUS audits will be evaluated at quarterly quality assurance meetings.	

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F 329	Continued From page 4 During review of the facility Tardive Dyskinesia Summary Form it was revealed R136's DISCUS was last completed on 6/27/13, which was over ten months overdue. When interviewed on 5/20/14, at 9:21 a.m. registered nurse (RN)-A who was the MDS coordinator verified the DISCUS was late but indicated the assessment was done every other with the Psychiatrist at Hennepin County Medical Center (HCMC) and was going to call to see what the score was and would be letting the surveyor know because it was supposed to be completed every six months. When interview on 5/20/14, at 10:19 a.m. the program director (PD) stated the DISCUS was not there as R136 was supposed to see the psychiatrist in December 2013, but the appointment had been canceled and when asked who was responsible to make sure it was completed PD stated it was the person who was scheduling and preparing the paper work for the appointment. -At 10:34 a.m. PD approached surveyor stated RN-A was on the phone at the moment to see if the psychiatrist had completed the DISCUS as indicated in the plan of care. -At 11:01 a.m. PD approached surveyor stated RN-A had confirmed there was no DISCUS done by the psychiatrist office. The medical record lacked evidence of any adverse side effect monitoring for the use of the psychtropic medication. On 5/20/14, at 12:57 p.m. director of nursing services (DNS) stated the facility was not in compliance and had completed the DISCUS on this day and provided a copy dated 5/20/14.	F 329		

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F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and documentation the consultant pharmacist failed to identify an irregularity and report to the physician and director of nursing services (DNS) that adequate adverse side effect monitoring had been completed for 1 of 5 residents (R136) who received antipsychotic medications. Findings include: R136's Physician Orders dated 5/7/10, and 4/29/14, indicated R136 was receiving antipsychotic's Risperdal 3 Milligrams (mg) by mouth (PO) at bedtime (HS) for schizophrenia and Seroquel 250 mg PO every bedtime for Paranoid Schizophrenia respectively. Additionally Physician Order dated 1/17/07, indicated R136 was receiving Cogentin 1 mg PO at HS (Medication used for treatment of extrapyramidal symptoms caused by antipsychotic medications and Parkinson's disease) R136's annual Minimum Data Set (MDS) dated	F 428	It is the practice of Andrew Residence to conduct in conjunction with the psychiatrist twice annual DISCUS assessments. DISCUS assessment was done the day it was identified. A review of all facilities DISCUS assessments was completed to ensure their timely completion. The DON or designee will conduct a review of DISCUS assessments on a quarterly basis to ensure their timely completion going forward. If the psychiatrist does not complete the assessment within the scheduled time frame qualified Andrew staff will complete the assessment. The consulting pharmacist will monitor in monthly reviews and the results of DISCUS audits will be evaluated at quarterly quality assurance meetings.	6/12/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 428	Continued From page 6 3/29/14, indicated R136's diagnoses included schizophrenia, unspecified extrapyramidal disease and abnormal movement disorder and Insomnia. In addition the MDS indicated R136 received antipsychotic's seven days a week, had hallucinations and other behavioral symptoms not directed towards others. Care Area Assessment (CAA) dated 3/29/14, indicated R136 had persistent mental illness was prescribed the medications Seroquel and Risperdal. The CAA directed medication side effect monitoring to be done bi-annually using the MOSES (Monitoring Of Side Effects Scale) and DISCUS tools and in addition medications were reviewed every three months with his psychiatrist and consulting pharmacist. R136's Annual Treatment Plan Review dated 4/10/14, indicated R136 had symptoms of mental illness which included auditory hallucinations, aggressive behavior towards people and withdrawal/isolation. Goal "Will learn to manage symptoms of mental illness and learn about schizophrenia..." Plan indicated R136 was expected to "Meet with [Program Manager] to discuss symptoms, side effects, and coping skills weekly." Review of the facility Tardive Dyskinesia Summary Form it was revealed R136's DISCUS was last completed on 6/27/13, which was over ten months over due. During further document review it was revealed the monthly consultant pharmacist (CP) Medication Regimen Review dated 8/3/13, through 5/6/14, the over due DISCUS had not been identified by the CP.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E116	A. BUILDING _____ B. WING _____	05/20/2014

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

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F 428	Continued From page 7 When interviewed on 5/20/14, at 9:21 a.m. registered nurse (RN)-A who was the MDS coordinator verified the DISCUS was late but indicated the assessment is done everyother with the Psychiatrist at Hennepin County Medical Center (HCMC) and was going to call to see what the score was and would be letting the surveyor know because it was supposed to be completed every six months. When interview on 5/20/14, at 10:19 a.m. the program director (PD) stated the DISCUS was not there as R136 was supposed to see the psychiatrist in December 2013, but the appointment had been canceled and when asked who was responsible to make sure it was completed PD stated it was the person who was scheduling and preparing the paper work for the appointment. -At 10:34 a.m. PD approached surveyor stated RN-A was on the phone at the moment to see if the psychiatrist had completed the DISCUS as indicated in the plan of care. -At 11:01 a.m. PD approached surveyor stated RN-A had confirmed there was no DISCUS done by the psychiatrist office. On 5/20/14, at 12:57 p.m. director of nursing services (DNS) stated the facility was not in compliance and had completed the DISCUS on this day and provided a copy dated 5/20/14. On 5/20/14, at 2:43 p.m. the interim consultant pharmacist was called but was not available. The medical record lacked evidence of any adverse side effect monitoring for the use of the psychtropic medication.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E116	A. BUILDING _____ B. WING _____	05/20/2014

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ANDREW RESIDENCE	1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404

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F 465	Continued From page 8	F 465		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain resident equipment in a clean and good repair for 4 of 4 residents (R109, R40, R34, R160) who shared a bathroom (room 405) reviewed for environmental concerns. Findings include: During an environmental tour on 5/20/14, at 10:25 a.m. with maintenance engineer (ME) and director of support services (DSS), a toilet riser was observed to be in disrepair. The left arm rest of the toilet riser was observed to be worn and have missing pieces of plastic, making an uneven, rough and uncleanable surface. ME and DSS verified the finding and stated they were not notified of the issue. R109's Minimum Data Set (MDS) dated 2/19/14, noted R109's cognitive skills for daily decision making indicated R109 had some difficulty in new situations. R109 was independent with activities of daily living (ADLs) which included toileting. R40's quarterly MDS dated 5/7/14, indicated R40 had moderate cognitive impairment and was independent with ADL's which included toileting.	F 465	It is the practice of Andrew Residence to ensure that all medical equipment is in good working order and able to meet infection control standards. The toilet assist device in question was immediately replaced. Toilet assist in use in the facility will be cleaned and maintained on a regular basis and repair tickets will be initiated as needed. Documentation will be reviewed monthly indicating that this equipment is safe, functional and sanitary. The Quality Coordinator will oversee the completion of quality checks and report to the quality assurance committee on the results of these checks.	6/17/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E116	A. BUILDING _____ B. WING _____	05/20/2014

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

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F 465	Continued From page 9 R34's annual MDS dated 2/17/14, indicated R34 was cognitively intact and independent with ADL's which included toileting. R160's annual MDS dated 3/28/14, indicated R160 was cognitively intact and independent with ADL's which included toileting. During an interview on 5/20/14, at 2:34 p.m. DSS stated that all staff are responsible for reporting any issues and all staff and residents can make out a repair ticket, "housekeeping is probably in the room most often, they should have seen and reported it." Review of the facility Housekeeping Safety Program dated 4/11/94, indicated "to prevent potential safety hazards, monitor work areas and complete a repair ticket for all required repairs." Review of the facility Repair Ticket Procedure dated 4/27/09, indicated "to ensure that Andrew Residence is maintained in good physical condition, and that building/equipment repairs are made on a priority basis, staff members will complete a Repair Ticket whenever repair and/or maintenance work is needed."	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E116	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/21/2014**

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

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Andrew Residence was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Andrew Residence is a 5-story building with a basement. The building was constructed in 1973, with an addition in 1978 and was determined to be of Type II(222) construction. Each floor of the facility is divided into 2 smoke zones by a smoke barrier. The entire building is protected with a complete automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a fire alarm system with corridor smoke detection and in common areas that are on the fire alarm system. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 212 beds and had a census of 211 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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.