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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

ID: MHI1

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY**

Facility ID: 00160

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/22/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
**12/31**

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Lisa Hakanson, HPR Dietary Specialist 01/22/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 01/28/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**03001**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

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

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

CMS Certification Number (CCN): 24-5520

January 28, 2015

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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective January 2, 2015 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.

Please contact me if you have any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
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*

February 11, 2015

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

RE: Project Number S5520025 and H5520055. Please Note, this letter amends the letter issued 1/22/15

Dear Mr. Colgan:

On December 18, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 24, 2014 that included an investigation of complaint number H5520055. 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 January 22, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 24, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 2, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 24, 2014, effective January 2, 2015 and therefore remedies outlined in our letter to you dated December 18, 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. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

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

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

## Post-Certification Revisit Report



| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245520 | A. Building<br>B. Wing | 1/22/2015 |

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

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

| (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|---|---|---|---|---|---|
| ID Prefix **F0242**<br>Reg. # **483.15(b)**<br>LSC | Correction Completed **01/02/2015** | ID Prefix **F0246**<br>Reg. # **483.15(e)(1)**<br>LSC | Correction Completed **01/02/2015** | ID Prefix **F0279**<br>Reg. # **483.20(d), 483.20(k)(1)**<br>LSC | Correction Completed **01/02/2015** |
| ID Prefix **F0282**<br>Reg. # **483.20(k)(3)(ii)**<br>LSC | Correction Completed **01/02/2015** | ID Prefix **F0318**<br>Reg. # **483.25(e)(2)**<br>LSC | Correction Completed **01/02/2015** | ID Prefix **F0323**<br>Reg. # **483.25(h)**<br>LSC | Correction Completed **01/02/2015** |
| ID Prefix **F0329**<br>Reg. # **483.25(l)**<br>LSC | Correction Completed **01/02/2015** | ID Prefix **F0428**<br>Reg. # **483.60(c)**<br>LSC | Correction Completed **01/02/2015** | ID Prefix **F0431**<br>Reg. # **483.60(b), (d), (e)**<br>LSC | Correction Completed **01/02/2015** |
| ID Prefix **F0441**<br>Reg. # **483.65**<br>LSC | Correction Completed **01/02/2015** | ID Prefix **F0465**<br>Reg. # **483.70(h)**<br>LSC | Correction Completed **01/02/2015** | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| Reviewed By State Agency | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| | GL/AK | 01/22/2015 | 28230 | 01/22/2015 |
| **Reviewed By CMS RO** | **Reviewed By** | **Date:** | **Signature of Surveyor:** | **Date:** |
| | | | | |

| Followup to Survey Completed on: | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? | YES | NO |
|---|---|---|---|
| 11/24/2014 | | | |

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

ID: MHI1

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY**

Facility ID: 00160

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/24/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
**12/31**

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Douglas Stevens, HFE NE II 01/06/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 01/12/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**03001**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

Certified Mail # 7010 1670 0000 8044 4561

December 17, 2014

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

RE: Project Number S5520025

Dear Mr. Colgan:

On November 24, 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. In addition, at the time of the November 24, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number 5520055.

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. In addition, at the time of the November 24, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number 5520055 that was found to be substantiated.

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

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

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

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

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

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

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

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

**DEPARTMENT CONTACT**

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

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

Email: gayle.lantto@state.mn.us
Telephone: (651) 201-3794
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 January 3, 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 January 3, 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 February 24, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 24, 2015 (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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

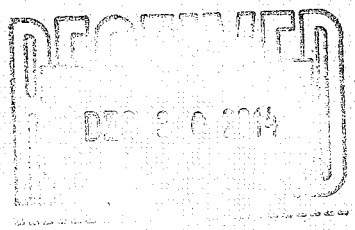
Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245520 | A. BUILDING _____ B. WING _____ | 11/24/2014 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>The facility's plan of correction (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.<br><br>Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.<br><br>An investigation of complaint H5520055 was completed. The complaint was substantiated at F465. | F 000 |  | |
| F 242 SS=E | 483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES<br><br>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to provide a choice in bathing frequency and/or a choice between a tub bath or shower for 7 of 18 residents (R26, R45, R29, R190, R184, R186, R173) interviewed.<br><br>Findings include: | F 242 | POC accepted by Fanta 1/6/15<br><br>F242<br>It is the facility's practice to acknowledge and advocate for each resident's right related to choice and concerning aspects of their interests. Resident's identified in this area (R26, R45, R29, R190, R184, R186, and R173) have been interviewed regarding their bathing/showering preferences and care plans updated to reflect their preferences. On-going, resident bathing preferences will be discussed with each resident at their next care conference. IDT educated on need to include bathing preferences in care conference discussions. Bathtubs have been cleaned. Nursing staff re-educated on offering choices regarding bathing.<br>Continued on next page. | 1/2/15 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Jenny W Colgan | Administrator | 12/29/14 |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245520 | A. BUILDING _____ B. WING _____ | 11/24/2014 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 242 | Continued From page 1<br>R26 reported taking a tub bath was not an option, when interviewed on 11/18/14, at 6:24 p.m. . R26 stated, "Never been asked if I want to take a bath. Sometimes my body aches from MS [multiple sclerosis]. A good soak would feel good at times." R26 had resided in the facility for several years. R26 also wanted more frequent bathing and said, "I have asked for more than one time a week but they say, 'don't have enough staff.' I know it takes a toll on staff."<br><br>R45 felt there was no option for taking a tub bath, when interviewed on 11/19/14, at 9:07 a.m. R45 explained, "A tub bath is not an option as none of them work. They just sit there." R45 also wanted more frequent bathing and reported, "Lucky if you get one a week. If you miss your day forget it, you will have to wait until the following week. I have asked for more and staff said no."<br><br>R29 expressed a desire for more frequent bathing on 11/19/14, at 2:20 p.m. but said he had never told anyone. The resident explained that he did not have a choice as to how often he received a bath.<br><br>R190 felt there was no choice regarding bathing frequency. On 11/19/14, 10:50 a.m. the resident stated, "When I ask they say they need to check, then usually nothing happens."<br><br>R184 stated there was no choice regarding bathing frequency on 11/19/14, 10:31 a.m. R184 stated, "I take one shower a week. I would like more as my hair is oily and looks greasy. I asked staff and was told it has to go to the board for review."<br><br>R186 reported there was no option at the facility | F 242 | Continued from pg1<br>Random audits of care conferences to ensure that resident preferences are identified will be conducted and reviewed routinely by the QA team to determine frequency and duration of audits.<br><br>Nurse Managers and IDT members are responsible for compliance;<br>Director of Nursing is responsible for overall compliance.<br><br>Completion date: 01/02/2015 | |

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| F 242 | Continued From page 2<br>for taking a tub bath, when interviewed on 11/19/14, 9:04 a.m. R186 said she had never had one. In a follow up interview on 11/20/14, at 2:50 p.m. R186 said, "I would have said yes to a bath."<br><br>R173 requested the surveyor observe the spa room on first floor on 11/20/14, at 11:45 a.m. The tub was visibly unclean with dust and debris in the bottom of the tub. In addition, a towel and miscellaneous pieces of equipment were stored in the tub. R173 reported she had been told by staff it was not working because it leaked.<br><br>On 1/21/14, at 1:34 p.m. a registered nurse (RN)-C was unsure if the 1st floor tub was in working order. RN-C was also unsure whether residents were offered a choice between a tub bath or shower. RN-C explained that staff usually just informed the resident, "It's time for your shower."<br><br>On 11/24/14, at 9:10 a.m. a nursing assistant (NA)-D stated she had not used the tub in the spa room "in a while" as no residents had asked for a tub bath. NA-D said, "It wasn't working the last time I tried to used it. "<br><br>On 11/24/14, at 9 :55 a.m. RN-B commented that she could not remember when the 3 west spa tub had last been working, and said residents who wanted a tub bath had to go to the first floor. RN-B believed the first floor tub was the only working tub in the building.<br><br>On 11/24/14, at 2:55 p.m. RN-B explained there was a bath schedule for each resident to bathe once a week, but they could bathe more frequently if desired. RN-B explained that a few residents from second floor received two baths a | F 242 | | |

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| F 242 | Continued From page 3<br>week without a problem. RN-B went on to explain that although the need for assistance was reviewed at care conference meetings, typically the bath schedule was not, unless "brought up" by the resident.<br><br>On 11/24/14, at 10:10 a.m. the maintenance director said the only working tub in the facility was on first floor, and there were no plans for repairing the tubs that were not in working order. However, at 10:30 a.m. the administrator reported the facility's capital plan for 2015 included working tubs on each floor, but they were "very expensive" and most residents preferred showers. The administrator was unsure whether residents were offered a choice between a shower or bath on their bath day, but later clarified with NA-E that residents were bathed according to their preference.<br><br>On 11/24/14, at 10:35 trained medication aide (TMA)-A explained that residents were asked their preference on admission and periodically, maybe monthly, but most preferred showers. TMA-A said if a resident wanted to have a bath they would need to go to the first floor, as the second floor tub was not working. TMA-A had not known any resident to leave the floor for a tub bath for three to four months.<br><br>On 11/24/14, at 10:57 a.m. NA-F reported the first floor tub did not work, "and no one right now has orders for a tub bath." At 10:59 a.m. RN-D said she had been employed at the facility since the summer and had never seen the tub utilized in that time. RN-D did not know if the tub on first floor worked and had not heard of anyone requesting a bath. RN-D said residents were given a choice when admitted and work with the | F 242 | | |

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| F 242 | Continued From page 4<br>resident to schedule the shower day. At 11:30 a.m. RN-A said she had never seen the 1st floor tub used, and thought it was getting repaired.<br><br>On 11/24/14, at 11:06 a.m. the maintenance director verified the three west and one west tubs both were in working order. The first floor tub was was in the same condition as previously observed with dust and debris on the bottom of tub, a towel and miscellaneous pieces of equipment in the tub. The third floor tub was found to have dust and debris including a cotton ball and red and brown colored drips and stains. There were also dark scuff marks on the interior of the tub.<br><br>On 11/24/14, at 11:30 the corporate director of quality assurance reported the facility did not have policies regarding resident bathing. | F 242 | | |
| F 246 SS=E | 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES<br><br>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide equipment for bathing in a timely manner for 1 of 1 resident (R186) reviewed for activities of daily living, provide nutritional services to meet the needs of 1 of 1 resident (R186) sampled for nutrition, and to | F 246 | F 246<br>It is the facility's practice to honor a resident's right to reside and receive services in the facility with reasonable accomodations of individual needs and preferences, except when the health or safety of the individual or other resident would be endangered.<br><br>DIETARY- PREFERENCES:<br>The resident was re-interviewed on 11/21/2014 and care plan has been updated to include resident preferences.<br>Continued on next page | 1/2/15 |

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| F 246 | Continued From page 5<br>maintain water temperatures acceptable to residents for bathing, potentially affecting 126 residents residing on the west end of the building.<br><br>Findings include:<br><br>R186's preference for smaller portions offered more frequently due to gastric bypass was noted in the Care Conference Report documentation dated 11/6/14. Notes indicated the plan was to be arranged.<br><br>On 11/20/14, at 12:00 p.m. R186 was interviewed. She explained, "I had a gastric bypass and I'm supposed to have a snack. But that is not an option here, so my mom brought snacks in for me. I brought it up a couple of times and they say 'okay'. I can ask for a snack, but just get a cookie or something, when I want something high in protein."<br><br>On 11/21/2014, at 2:17 p.m. the food service director was interviewed. She explained the unit refrigerators were stocked with a variety of food items such as milk, juice, sandwiches, yogurt, cottage cheese, peanut butter, dry cereal, ice cream, bead, cookies, and fruit. Residents were allowed to access the food independently. She verified R186 did not receive a scheduled snack.<br><br>An initial nutritional assessment dated 10/20/14, revealed R186 had nutritional risks, tolerated a regular diet and consumed about 50% or more of most meals. R186 reported having a good appetite, had no problems with chewing or swallowing, was independent with eating and making choices, her skin was intact and laboratory testing results were reviewed. "Will provide meals as ordered." | F 246 | Periodic monitoring of care plans, resident choices, nutritional needs and supplements will be conducted by dietician and dietary manager to ensure compliance. The QA team to determine frequency and duration of monitoring.<br><br>Bathing: A proper shower chair was available in the facility prior to resident's admission. Chair was provided to resident and a shower was given on 11/20/2014.<br><br>Nursing staff educated on need to pursue accommodations with supervisors/maintenance/DON if proper equipment is not available to ensure resident's needs are met. Nursing staff re-educated on offering choices regarding bathing.<br><br>Nurse Managers are responsible for compliance;<br>Director of Nursing is responsible for overall compliance.<br><br>Continued on next page | |

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| F 246 | Continued From page 6<br><br>The nutrition care plan reviewed on 11/20/14, indicated a potential for alteration nutritional status. The goal was to remain well hydrated and within five pounds of admit weight. Approaches included: to encouraging adequate fluid intake with meals; monitor and record quarterly amount eaten; provide ordered diet. The care plan lacked any mention of frequent small meals. A subsequent care plan provided by the facility on 11/24/14, included a nutritional problem with a revision date of 11/23/14. The new plan included an approach to provide snacks per resident request. A snack schedule was developed with the items to be placed in the unit refrigerator for resident to access independently.<br><br>R186 reported on 11/19/14, at 8:59 a.m. that she had not had a bath or shower since her admission on 10/27/14, as the facility did not have an appropriate sized bathing chair. In more than three week's time she had only had her hair washed once with a dry shampoo supplied by a family member. R186 said she had received a bed bath once or twice a week. The resident believed a larger chair had been ordered.<br><br>The following day, at 2:45 p.m. R186 stated, "I had my first bath today because, they did not have the proper showering chair. I got so sick of my hair I went down to the beauty shop and paid them to clean it. Then, after that I find out the large shower chair was in. So, I paid and then I could have a shower."<br><br>On 11/21/14, at 1:34 p.m. a registered nurse (RN)-C was interviewed. RN-C explained that at the time of R186's admission, they were working on pain control. RN-C was unsure whether the | F 246 | WATER TEMPS<br>Maintenance was aware of occasional water temperature fluctuations and would immediately adjust temperatures through the use of a mixing valve. Post review from a plumbing contractor detected a problem with the plumbing design causing irregularities with the mixing valve. The contractor has been procured and improvements are scheduled to be installed.<br><br>Water temperature monitoring will continue to be done periodically to ensure compliance. The QA team to determine frequency and duration of reporting audit results to the QA team.<br><br>Responsible person: Maintenance Director<br>Completion date: 01/02/2015 | |

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| F 246 | Continued From page 7<br>resident was being provided showers or bed baths, and had not direct knowledge of the resident's bathing plan. RN-C stated, "All I heard was that she tried to get in the shower once but the chair did not fit her. I went searching for a bariatric chair just yesterday. We had the chair in the building, but it wasn't on our floor." RN-C said the situation had not been brought to his attention until this week. When asked about hair washing for residents with bed baths RN-C stated, "I'm not sure how hair washing gets done here." When asked about the beauty shop, RN-C answered, "Yes, they could do it at the beauty shop." RN-C reported being unaware R186 was not getting her hair washed. RN-C was also unsure whether the bathtub was in working order.<br><br>On 11/24/14 at 1:08 p.m. the director of nursing (DON) was interviewed. She explained that R186 had been refusing frequently to get out of bed. The DON said the facility did have a blow up hair washing apparatus for use when residents could not get out of bed. Water could be used to wash the hair and drained into a basin.<br><br>The Care Conference Report for R186, dated 11/6/14, indicated the team discussed getting showers one to two times weekly as the resident tolerated. R186 had also been encouraged to get out of bed more.<br><br>R186's care plan revealed needs related to dressing, grooming and bathing due to weakness from a medical condition. The goal was for R186 to appear clean, well groomed, and appropriately dressed. Interventions included assist of one with bath and shower, use of the bariatric shower chair, and assistance with grooming and hygiene. The plan was developed on 11/21/14, which was | F 246 | | |

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| F 246 | Continued From page 8<br>3 1/2 weeks after the resident's admission.<br><br>A facility policy titled Care Plans and Care conferences, dated 11/14, indicated the integrated plan of care was to meet the physical, social, psychological, and spiritual needs and problems of each resident, through the use of a multidisciplinary team approach. The plan of care was to be completed no later than twenty-one days after admission.<br><br>On 11/20/14 at 11:45 a.m. R173 said the water temperature in the spa room on first floor did not get up to a comfortable temperature, even after letting it run for a while. The spa room was observed at the same time. The sink faucet was turned on and the water was let to run for about 1-2 minutes. Although the water felt warm to the touch, it was not at a temperature warm enough to shower.<br><br>At 12:41 p.m. the water temperature was tested by the maintenance director in each of three spa rooms on the west side of the facility. The temperatures were 105.7 degrees Fahrenheit (F) for the first floor spa room, 106.5 degrees F for the second floor spa room and 107.3 degrees F for the third floor spa room. The maintenance director said the goal was for temperatures between 105-110 F. The administrator said he thought the temperature felt adequate. The maintenance director and administrator were not aware of complaints of cold water for bathing.<br><br>11/20/14, at 2:50 p.m. R186 said she had a shower earlier and, "It started out okay, but after five minutes was pretty cool. I hear others complain about it." At 2:55 p.m. R185 reported, "You are lucky if you get hot water." On 11/21/14, | F 246 | | |

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| F 246 | Continued From page 9<br>at 11:00 a.m. R 168 said, "You can't take a warm shower between 7:00 a.m. and 7:00 p.m."<br><br>The facility policy titled Water Temperature management, dated 6/22/13, directed staff to ensure a safe and adequte water temperatures through out the facility. Water temperatures were to be maintained within regulatory guidelines of between 105 and 115 degrees F.<br><br>The facility provided daily water temperature inspection logs. The logs indicated resident rooms had been monitored, but lacked monitoring of the spa rooms. The log dated 11/20/14, indicated the circulation pump (send), for the middle building, was to be between 105-115 degrees F. The log indicated the send temperature was 103 degrees F. The return temperature was also to be 105-115 degrees F. The return temp was documented as 106 degrees F. The log dated 11/22/14, indicated a send temperature of 104 degrees F and return temperature of 103 degrees F. The log dated 11/23/14 indicated a send temperature of 104 degrees F and a return temperature of 102 degrees F. | F 246 | | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive | F 279 | F279<br>It is the facility's practice to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br>Continued on next page | 1/2/15 |

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| F 279 | Continued From page 10<br>assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to develop a comprehensive care plan for 1 of 5 residents (R26) reviewed for unnecessary medication.<br><br>Findings include:<br><br>R26 lacked a plan of care to address diabetes, medication management (insulin) and an acceptable blood sugar goal.<br><br>On 11/18/14, at 6:13 p.m. R26 was interviewed and reported staff "insist on giving me insulin--I have no symptoms of diabetes so don't want any injections. This has been going on for about a month."<br><br>A dietary progress noted dated 3/5/14, noted the resident had a new diet order on 2/26 for a diabetic diet--limit CHO (consistent carbohydrate) sweets. "Resident with multiple diet orders in matrix--sent fax requesting to clarify diabetic, no added salt, small portions. Resident labs taken 2/24 A1c [measurement of average glucose in | F 279 | Nutrition care plan for R26 was updated to reflect diabetic needs on 12/22/2014. Residents requiring interventions for diabetes have a care plan in place reflecting that diagnosis as of 12/23/2014.<br><br>IDT was re-educated on 12/4/2014 on facility policy that comprehensive care plans are to be developed by day 21 of admission and updated on an ongoing basis whenever changes are noted.<br><br>Responsible Persons: Dietary Manager and IDT; Director of Nursing is responsible for overall compliance.<br><br>Completion date: 01/02/2015 | |

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

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| F 279 | Continued From page 11<br>blood over a prolonged period of time] 6.3 (high), glucose 126 (high). I spoke with resident regarding the diabetic diet & he states, 'I don't have diabetes.' I informed of these labs & that the diet will help prevent A1c from worsening and preventing need for medication/insulin to manage blood sugars. He was appreciative of reviewing the diet & I provided handouts for him to have on carb [carbohydrate] counting. I encouraged him to limit sweets, juice, regular pop & extra breads/starches at meals. We discussed alternative breakfast options as he usually eats pancakes. He continues to request small portions for goal of weight loss & low salt diet continues for heart health."<br><br>A physician's dated 4/7/14, "New diagnoses of diabetes but stable with diet." Current physician's order revealed that on 10/16/14, R26 was ordered Novolin N (long acting) insulin 8 units subcutaneously every morning and Novolog (fast acting) insulin four times based on blood sugar reading.<br><br>R26's care plan was updates 11/19/14, and identified the resident at risk for risk for aspiration with diagnosis of dysphasia (related to multiple sclerosis). "Resident does not want altered diet and is aware of speech therapy recommendations, history of weight fluctuating due to often trying to lose weight, picks and chooses which meals he comes to based on how hungry he and often snacks on chips in his room." Approaches indicated regular diabetic, low sweets and carbohydrates. The care plan lacked any mention of diabetes, insulin use or the identification of an appropriate blood sugar range.<br><br>During interview on 11/24/14, at 10:55 a.m. a | F 279 | | |

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| F 279 | Continued From page 12<br>registered nurse (RN)-B reviewed the current care plan and confirmed the diabetes diagnosis, medication use (insulin) and blood sugar goal was not identified on the care plan. RN-B further stated it was the responsibility of the nursing and dietary departments to ensure this was noted on the resident's care plan. | F 279 | | |
| F 282 SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to implement the care plan for nursing rehabilitative services to promote range of motion (ROM) for 1 of 3 residents (R26) reviewed for rehabilitative services.<br><br>Findings include:<br><br>R26's care plan reviewed 11/19/14, indicated R26 was at risk for a decline in ROM related to immobility, arthritis, paralysis, progression of multiple sclerosis, and a left upper extremity contracture. The goal was for the resident to maintain ROM in his upper and lower extremities. Staff was directed to provided PROM to all extremities twice daily.<br><br>R26 was observed the morning of 11/21/14, at 8:48 a.m. while two nursing assistants (NA)-B and NA-C assisted the resident. The resident | F 282 | F282<br>It is the practice of the facility to provide range of motion services by qualified persons in accordance with each resident's care plan.<br>Restorative program for R26 was reviewed and remains appropriate.<br>Nursing staff re-educated on how to perform ROM programs as ordered and proper steps to take if the programs cannot be completed.<br><br>Random audits will be reviewed routinely by the QA team to determine frequency and duration of audits.<br><br>Responsible Persons: Nurse Managers; Director of Nursing is responsible for overall compliance.<br><br>Completion date: 01/02/2015 | 1/2/15 |

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| F 282 | Continued From page 13<br>was transferred from the bed to the chair using an E-Z Lift (to mechanically aid in transfer). Staff assisted resident with peri-care, and adjusting clothing. NA-C reported the resident was able to independently perform oral care and face washing after set up by staff. At 9:19 a.m. R26 was wheeling himself out of his room toward the dining room for breakfast. When asked whether ROM had been provided the resident replied, "No. The aides are supposed to do it but don't."<br><br>On 11/24/14, at 8:35 a.m. NA-A was in the room with R26. She explained that she and another NA had just assisted R26 into the wheelchair from the bed using the E-Z Lift. NA then proceeded to set up oral care supplies and a wash cloth. NA-A then left the room. R26 again reported ROM had not been performed, and at 9:05 he wheeled himself to the dining room. After breakfast at 9:24 a.m. NA-A stated R26's room needed to be tidied up. She explained that once the resident was in his wheelchair "he is pretty much done." When NA-A was further interviewed at 9:50 a.m. NA-A explained ROM was performed "first thing" in the morning. The surveyor informed NA-A the resident had reported no ROM had been performed that day. NA-A then verified ROM had not been performed for the resident.<br><br>R26's quarterly Minimum Data Set (MDS) dated 7/23/14, included diagnoses of multiple sclerosis (MS) and hemiplegia (paralysis on one side of the body). The MDS indicated R26 was cognitively intact, was unable to walk, required extensive assistance with activities of daily living (ADLs), and had a range of motion (ROM) impairment on one side of upper and lower extremities. It was noted the resident was receiving restorative nursing including passive ROM five days weekly. | F 282 | | |

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| F 282 | Continued From page 14<br><br>The current physician orders dated 11/17/14, directed staff to perform "PROM [passive range of motion] BID [twice daily] 10 reps [repetitions] to all 4 extremities."<br><br>A registered nurse (RN)-B was interviewed on 11/24/14, at 2:53 p.m. and verified the NAs were instructed to perform PROM twice daily either with or after cares. RN-B said performing the PROM during cares would have been the most efficient. | F 282 | | |
| F 318 SS=D | 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide nursing rehabilitative services as ordered to maintain or increase range of motion (ROM) for 1 of 3 residents (R26) reviewed for rehabilitative services.<br><br>Findings include:<br><br>R26 was observed the morning of 11/21/14, at 8:48 a.m. while two nursing assistants (NA)-B and NA-C assisted the resident. The resident | F 318 | F318<br>It is the facility's practice that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion.<br><br>Restorative program for R26 was reviewed and remains appropriate. Nursing staff re-educated on need for restorative program to be completed as determined by a registered nurse and the process of documentation and reporting when a program cannot be completed for any reason.<br><br>Random audits will be reviewed routinely by the QA team to determine frequency and duration of audits.<br>Continued on next page | 1/2/15 |

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| F 318 | Continued From page 15<br>was transferred from the bed to the chair using an E-Z Lift (to mechanically aid in transfer). Staff assisted resident with peri-care, and adjusting clothing. NA-C reported the resident was able to independently perform oral care and face washing after set up by staff. At 9:19 a.m. R26 was wheeling himself out of his room toward the dining room for breakfast. When asked whether ROM had been provided the resident replied, "No. The aides are supposed to do it but don't."<br><br>On 11/24/14, at 8:35 a.m. NA-A was in the room with R26. She explained that she and another NA had just assisted R26 into the wheelchair from the bed using the E-Z Lift. NA then proceeded to set up oral care supplies and a wash cloth. NA-A then left the room. R26 again reported ROM had not been performed, and at 9:05 he wheeled himself to the dining room. After breakfast at 9:24 a.m. NA-A stated R26's room needed to be tidied up. She explained that once the resident was in his wheelchair "he is pretty much done." When NA-A was further interviewed at 9:50 a.m. NA-A explained ROM was performed "first thing" in the morning. The surveyor informed NA-A the resident had reported no ROM had been performed that day. NA-A then verified ROM had not been performed for the resident.<br><br>R26's quarterly Minimum Data Set (MDS) dated 7/23/14, included diagnoses of multiple sclerosis (MS) and hemiplegia (paralysis on one side of the body). The MDS indicated R26 was cognitively intact, was unable to walk, required extensive assistance with activities of daily living (ADLs), and had a range of motion (ROM) impairment on one side of upper and lower extremities. It was noted the resident was receiving restorative nursing including passive ROM five days weekly. | F 318 | Nurse Managers and staff education are responsible for compliance; Director of Nursing responsible for overall compliance.<br><br>Completion date: 01/02/2015 | |

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| F 318 | Continued From page 16<br><br>The current physician orders dated 11/17/14, directed staff to perform "PROM [passive range of motion] BID [twice daily] 10 reps [repetitions] to all 4 extremities."<br><br>R26's care plan reviewed 11/19/14, indicated R26 was at risk for a decline in ROM related to immobility, arthritis, paralysis, progression of multiple sclerosis, and a left upper extremity contracture. The goal was for the resident to maintain ROM in his upper and lower extremities. Staff was directed to provided PROM to all extremities twice daily.<br><br>A registered nurse (RN)-B was interviewed on 11/24/14, at 2:53 p.m. and verified the NAs were instructed to perform PROM twice daily either with or after cares. RN-B said performing the PROM during cares would have been the most efficient. | F 318 | | |
| F 323 SS=E | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, document review and interview the facility failed to properly maintain steam tables for safety prior to food service on 2 | F 323 | F323<br>It is the practice of the facility to ensure the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>Steam table lids were applied to the steam table pans on 11/21/14 and this application will continue to be used to prevent injury.<br>Continued on next page | 1/2/15 |

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| F 323 | Continued From page 17<br>of 2 kitchenettes. This had the potential to affect 3 of 3 residents (R166, R15, R190) who were cognitively impaired and independent in mobility who received meals in the 3 east dining room and 7 of 7 residents (R53, R5, R112, R30, R113, R94, R98) in the 2 east dining room.<br><br>Finding include:<br><br>Uncovered steam table pans were observed in the 3 east dining area on 11/20/14, at 10:55 a.m. In the 3 east kitchenette, the steam table was located behind a half wall, however, three of the four pans could have been accessed from the dining area from the other side of the half wall. Four steam table pans contained approximately 1 1/2 inches of water in the bottoms of each of the pans. At 11:39 a.m. the water in the pans was visibly steaming and with small bubbles in the water. At 11:45 a.m. five residents were seated in the dining room. At 11:48 a.m. a dietary aide (D)-A arrived on 3 east unit with food. At the request of the surveyor, D-A measured the temperature of the water, which registered 130 degrees Fahrenheit (F).<br><br>Prior to the evening meal on 11/20/14, at 4:00 p.m. the steam table in the 3 east kitchenette again had four uncovered steam table pans with approximately 1 1/2 inches of steaming and bubbling water on the bottoms of the pans. The stationary steam table was in the same location behind the half wall in the kitchenette.<br><br>Uncovered steam table pans were observed in the 2 east kitchenette on 11/20/14, at 4:18 p.m. The steam tables were behind a half wall. Four pans contained approximately 1 1/2 inches of water, not visibly steaming at the time. A plastic | F 323 | Dietary staff has been educated on proper cover application.<br>Random audits will be conducted to ensure resident safety and application of steam table covers and reviewed routinely by the QA team for duration and frequency.<br><br>Responsible person: Dietary Manager<br><br>Completion date: 01/02/2015 | |

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| F 323 | Continued From page 18<br>sheath extended from the top platform of the table and extended above the steam table pans, however, there was a space that could have been accessed from the the opposite side of the wall in dining room area.<br><br>The following day at 7:28 a.m. the 3 east kitchenette was again observed with four steam table pans containing approximately 1 1/2 inches of water on bottom of pans. D-A reported the steam table had just been turned on.<br><br>Facility incident logs for the previous six months were reviewed, and did not show any injuries had been sustained related to the hot water.<br><br>On 11/21/14, at 11:10 a.m. the director of dietary was interviewed. She had worked at the facility for several years and reported there had never been an incident or injury related to a resident inadvertently coming into contact with the hot water. She further explained that facility staff were always present in the dining area and residents "are monitored appropriately" on the units.<br><br>On 11/21/14, at 3:18 p.m. the director of nursing was interviewed and concurred there had been no incidents of incidents or injuries related to the hot water in the steam tables. The director of nursing acknowledged the steam tables could have posed a potential safety concern should a resident have accessed the water. | F 323 | | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any | F 329 | F329<br>It is the facility's policy that each resident's drug regimen must be free from unnecessary drugs.<br>Continued on next page | 1/2/15 |

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| F 329 | Continued From page 19<br>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.<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to document attempts at dose reduction of a anti-anxiety medication for 1 of 5 residents (R45) reviewed for unnecessary medication use and to utilize non-pharmacological interventions for insomnia prior to administration of hypnotic medication for 1 of 5 residents (R26) reviewed for unnecessary medication use.<br><br>Findings include:<br><br>R45's current physician orders revealed an order | F 329 | Pharmacy consultant completed recommendation paperwork for both R45 and R26 which were sent to the primary physician requesting dose reductions or proper documentation of reasons they do not feel a dose reduction is appropriate at this time. Both physicians responded with proper documentation on 12/5/2014, R45 has had a dose reduction in the antianxiety medication. Process implemented for obtaining documentation from outside physicians by medical records department. Nursing staff re-educated on requirement to offer and document non-pharmacological interventions prior to giving PRN medications.<br><br>Random audits of offering non-pharmacological interventions prior to PRN medication administration will be completed and will be reviewed routinely by the QA team to determine frequency and duration of audits. Pharmacy recommendations will be reviewed at quarterly QA meetings.<br>Continued on next page | |

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| F 329 | Continued From page 20<br>for buspirone 20 milligrams (mg) every day for generalized anxiety disorder. The medication was started on 5/7/12, without a change in the dosage since its initiation.<br><br>The care plan dated 7/11/13, identified "Resident receives anti-anxiety medication r/t [related to] diagnosis of anxiety. The following target behaviors have been observed: multiple health complaints and excessive call light use."<br><br>Behaviors were identified and monitored on all shifts for multiple health complaints and excessive call light use. Staff were directed to document the resident's behavior/mood whenever the two behaviors were observed, and were to document numbers of episodes that occurred during a shift. Staff was to document using the following codes: 1-redirect, 2-one on one visit, 3-refer to nurses' notes, 4-engaged in activity for distraction, 5-toileted, 6-given food, 8-given fluids, 9-changed positions, 10-adjusted room temperature, 11-back rub, 12-assessed for pain. In addition, staff were directed to document and outcome of response using the following codes: + = Improved, 0 = no change, - = behavior worsened. Medication side effects were to be documented in the nursing notes.<br><br>The physician progress notes revealed a lack of documentation to support the ongoing need of buspirone (Buspar). A psychiatric noted 3/7/14, indicated "On Cymbalta and Buspar for years." Recommendations from the psychiatrist were to "Consider taper of Buspar," however a taper of the medication had not been attempted since the time of the recommendation.<br><br>On 11/24/14, at 8:03 a.m. a nursing assistant | F 329 | Responsible persons: Nurse Managers with assistance of consultant pharmacist;<br>Director of Nursing is responsible for overall compliance.<br><br>Completion date: 01/02/2015 | |

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| F 329 | Continued From page 21<br>(NA)-F who consistently was assigned to work with R45 explained that the resident occasionally refused a bath usually if not feeling well. This did not occur some months and sometimes up to once a month. NA-F stated the resident did become upset or impatient over small things such as the inability to find her remote or glasses, yet when she put on her call light, staff would find the remote right in front of her or her glasses on top of her head. "We just get her what she wants, then will leave her alone and come back to talk to her--will let her calm down. This is usually effective."<br><br>On 11/24/14, at 2:59 p.m. a registered nurse (RN)-B was interviewed as to whether a dose reduction had been attempted. She stated she us unable to locate documentation in the past year that showed a dose reduction had been attempted. RN-B further stated that R45 consulted with physicians outside of the facility. No additional information was provided.<br><br>R26 received hypnotic medication with no non-pharmacological interventions documented. R26 had a current physician order dated 11/17/14, for Ambien (hypnotic medication used for sleep) 10 mg at bedtime as needed for insomnia. The hypnotic medication was originally ordered 5/11 with no change in order. The Medication Administration Record (MAR) indicated R26, was administered Ambien as follows in the previous four months:<br>1. 8/14--administered six times after R26 requested for sleep and complaints of pain<br>2. 9/14--administered twice after R26 requested for sleep<br>3. 10/14--administered once after R26 requested for sleep | F 329 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| REDEEMER RESIDENCE INC | 625 WEST 31ST STREET MINNEAPOLIS, MN 55408 |

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| F 329 | Continued From page 22<br>4. 11/1 to 11/24--administered seven times after R26 complained of insomnia/requested for sleep<br><br>On 11/21/14, at 8:48 a.m. R26 was interviewed and stated he had been sleeping better, and "They give me something to sleep. I was having really bad dreams from things that have happened in the past and would wake up and couldn't get back to sleep." Other then staff bringing him a "sleeping pill" when he requested it, he was unable to recall staff providing him with any other interventions to promote sleep.<br><br>The MAR for 8/14-11/14 directed staff to "Document on MAR non-pharmacological interventions tired before giving PRN [as needed] hypnotic by using this code: 1--assessed for discomfort, 2--reduced environmental noise, 3--refer to nurses notes, 4- provide snooze food, 5--dimmed/turned off lights, 6--1:1 visit to reduce anxiety or concerns, 7--given fluids, 8--changed position, 9--adjusted room temperature, 10--back rub, 11--identified unmet need, 13--identified change in status, 15--resident refused non-med approach, 16- PRN med given (see MAR). Document outcome or response." The documentation was lacking to support the use of non-pharmacological interventions attempted to promote sleep.<br><br>R26's care plan dated 7/25/11, identified the resident as Ambien for a diagnosis of insomnia. The goal was that the use of medication would result in no adverse effects and the resident would sleep at least six hours a night when used. Interventions directed staff to document non-pharmacological interventions tried on the MAR, before giving PRN hypnotic (as noted above), "Wishes to be undisturbed at night, Have | F 329 | | |

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| F 329 | Continued From page 23<br>resident call light within reach during the night, Keep door closed, Do not disturb him or enter his room during the night unless he puts on his call light. Attempt dose reduction per regulatory guidelines as condition warrants per physician/NP [nurse practitioner] orders, Document observations of behaviors and activities that reflect the resident's behavior/mood. Staff will offer HS [bedtime] snack, back rub, soft music, additional linens to promote comfort induce sleep before administering PRN Ambien, Suggest non-pharmacological approaches such as massage, warm milk. Ask resident what helps him to fall asleep. Monitor for drug use effectiveness and adverse consequences with use of sleep log PRN and/or by resident report after using PRN."<br><br>When interviewed on 11/24/14, at 2:50 p.m. RN-B acknowledged the medical record lacked documentation to indicate non-pharmacological interventions were attempted and their efficacy noted. Staff was unable to provide documentation that non-pharmacological interventions had been used prior to or in conjunction with the medication use. | F 329 | | |
| F 428 SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. | F 428 | F428<br>It is the facility's policy that the drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist and that the pharmacist report any irregularities to the attending physician and the director of nursing, and these reports be acted upon.<br>Continued on next page | 1/2/15 |

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| F 428 | Continued From page 24<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the consultant pharmacist failed to ensure medication regimens were free from unnecessary medications for 2 of 5 residents (R45, R26) reviewed for unnecessary mediation use.<br><br>Findings include:<br><br>R45's current physician orders revealed an order for buspirone 20 milligrams (mg) every day for generalized anxiety disorder. The medication was started on 5/7/12, without a change in the dosage since its initiation.<br><br>The physician progress notes revealed a lack of documentation to support the ongoing need of buspirone (Buspar). A psychiatric noted 3/7/14, indicated "On Cymbalta and Buspar for years." Recommendations from the psychiatrist were to "Consider taper of Buspar," however a taper of the medication had not been attempted since the time of the recommendation.<br><br>On 11/24/14, at 2:59 p.m. a registered nurse (RN)-B was interviewed as to whether a dose reduction had been attempted. She stated she us unable to locate documentation in the past year that showed a dose reduction had been attempted. RN-B further stated that R45 consulted with physicians outside of the facility. No additional information was provided.<br><br>No recommendations were noted in the consultant pharmacy drug regimen review from | F 428 | A house-wide audit of all resident drug regimens, including R45 and R26, was completed by the facility consultant pharmacist on 12/23/2014. The consultant pharmacist will continue to do thorough medication reviews to ensure all medications are necessary and appropriate. Pharmacy recommendations will be reviewed at quarterly QA meetings.<br><br>Director of Nursing is responsible for compliance; Quality Assurance team is responsible for overall compliance.<br><br>Completion date: 01/02/2015. | |

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| F 428 | Continued From page 25<br>1/14 to the most recent review dated 11/20/14, related to the resident's use of buspirone.<br><br>During an interview on 12/15/14, at 4:15 p.m. the consultant pharmacist stated R45 had experienced numerous medication changes and medical issues over the past year. The pharmacist stated she attempted to only make one medication reduction at a time and when the resident was well. The pharmacist indicated she had not made any recommendation for Buspar in the last year.<br><br>R26 received hypnotic medication with no non-pharmacological interventions documented. R26 had a current physician order dated 11/17/14, for Ambien (hypnotic medication used for sleep) 10 mg at bedtime as needed for insomnia. The hypnotic medication was originally ordered 5/11 with no change in order. The Medication Administration Record (MAR) indicated R26, was administered Ambien as follows in the previous four months:<br>1. 8/14--administered six times after R26 requested for sleep and complaints of pain<br>2. 9/14--administered twice after R26 requested for sleep<br>3. 10/14--administered once after R26 requested for sleep<br>4. 11/1 to 11/24--administered seven times after R26 complained of insomnia/requested for sleep<br><br>On 11/21/14, at 8:48 a.m. R26 was interviewed and stated he had been sleeping better, and "They give me something to sleep. I was having really bad dreams from things that have happened in the past and would wake up and couldn't get back to sleep." Other then staff bringing him a "sleeping pill" when he requested | F 428 | | |

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| F 428 | Continued From page 26<br>it, he was unable to recall staff providing him with any other interventions to promote sleep.<br><br>The MAR for 8/14-11/14 directed staff to "Document on MAR non-pharmacological interventions tired before giving PRN [as needed] hypnotic by using this code: 1--assessed for discomfort, 2--reduced environmental noise, 3--refer to nurses notes, 4- provide snooze food, 5--dimmed/turned off lights, 6--1:1 visit to reduce anxiety or concerns, 7--given fluids, 8--changed position, 9--adjusted room temperature, 10--back rub, 11--identified unmet need, 13--identified change in status, 15--resident refused non-med approach, 16- PRN med given (see MAR). Document outcome or response." The documentation was lacking to support the use of non-pharmacological interventions attempted to promote sleep.<br><br>When interviewed on 11/24/14, at 2:50 p.m. RN-B acknowledged the medical record lacked documentation to indicate non-pharmacological interventions were attempted and their efficacy noted. Staff was unable to provide documentation that non-pharmacological interventions had been used prior to or in conjunction with the medication use.<br><br>During an interview on 12/15/14, at 4:15 p.m. the consultant pharmacist stated she generally reviewed nursing notes, MARs, and care plans during her reviews to ensure non-pharmacological interventions were being used prior to administration of hypnotic medication. The pharmacist stated if documentation was lacking, she made a recommendation to nursing staff. The pharmacist reviewed her notes for the previous | F 428 | | |

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| F 428 | Continued From page 27<br>six months and indicated she "did not make any recommendations for nursing." | F 428 | | |
| F 431 SS=E | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. | F 431 | **F431**<br>It is the facility's procedure that all drugs will be labeled in accordance with currently accepted professional principles and include the expiration date when applicable.<br><br>Nurse involved in expired insulin and nurse managers involved in failure to date flu vaccine vials were re-educated immediately during survey. Nursing staff educated on facility policy for expiration of medications and dating items when opened as indicated on the policy.<br><br>Random audits will be completed and will be reviewed routinely by the QA team to determine frequency and duration of audits.<br><br>Nurse Managers are responsible for compliance; Director of Nursing is responsible for overall compliance.<br><br>Completion date: 01/02/2015 | 1/2/15 |

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| F 431 | Continued From page 28<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure medications with shortened use dates were properly dated after opening potentially affecting newly admitted residents. In addition, an expired Novalog insulin vial (for diabetes) was stored for use in the medication cart, potentially affecting 1 of 1 resident (R80) whose medication had expired and was stored for use.<br><br>Findings include:<br><br>On 11/18/14, at 12:35 p.m. the facility's medication storage system was observed on the 2 east unit with a licensed practical nurse (LPN)-A. The refrigerator in the medication storage room contained two vials of influenza immunization solution. The first vial was unopened and stored in a zippered plastic bag, labeled with a hand-written date of 10/2/14. The second vial of influenza solution was opened, however the opened date had not been recorded on the label. LPN-A verified both vials of house stock multi-use influenza solution should have been dated when opened. She further explained that the use of a date on the plastic bag could have been "misleading" and said she planned to throw away the solution.<br><br>On 11/18/14, at 1:50 p.m. two vials of influenza immunization solution were stored for use in the refrigerator in the medication storage room on the transitional care unit (CU). The vials were also in a zippered plastic bag, labeled with a hand-written date of 10/02/14 on the bag. One of the vials was opened, but was not labeled with an | F 431 | | |

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| F 431 | Continued From page 29<br>opened date. In addition, a vial of Tubersol (a solution for testing for tuberculosis) was stored on the refrigerator shelf. The vial of Tubersol was not labeled with an opened date. A registered nurse (RN)-E then verified the findings and stated both of the opened vials should have been dated when opened.<br><br>On 11/20/14, at 7:35 a.m. during medication administration observation on the TCU, RN-A drew up 6 Units (U) of Novalog insulin for R80. The surveyor stopped RN-Just prior to administering the medication, and informed the RN the insulin had expired. RN-A explained she mistook the expired date as the opened date. She verified this was the only vial of Novalog insulin available for R80.<br><br>R80's physician order dated 10/19/14, directed staff to administer Novalog insulin 6U three times daily at 8:00 a.m., 12:00 p.m., and 5:00 p.m. to manage diabetes mellitis type II.<br><br>An interview on 11/20/14, at approximately 11:00 a.m., the Merwin pharmacist consultant (PC)-A stated she expected all multi-use vials to be dated when opened and discarded according to the Merwin medication storage policy because of the possibility of decreased effectiveness.<br><br>On 11/20/14, at approximately 3:00 p.m. the director of nursing reported staff was trained to follow the policy and procedure of drug storage. She would expect staff to date multi-use medications with a shortened use date when opened and to discard them when they expired.<br><br>The undated Merwin LTC Pharmacy Medication Storage and Expiration Guidelines, directed staff | F 431 | | |

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| F 431 | Continued From page 30<br>to date insulin, tuberculin and influenza vaccine vials when opened, to discard insulin and influenza vaccine vials 28 days after opening and to discard tuberculin vials 28 days after opening. | F 431 | | |
| F 441 SS=E | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens | F 441 | F441<br>It is the facility's policy to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>The nurse identified in this tag was immediately re-educated on date noted by surveyor. Nurse was interviewed and was aware of proper sanitation procedure but became nervous with surveyor present. Nursing staff re-educated on the facility policy and procedure for sanitizing glucometer machines with each use. Random audits will be completed and will be reviewed routinely by the QA team to determine frequency and duration of audits.<br><br>Nurse Managers and Infection Control Nurse are responsible for compliance; Director of nursing is responsible for overall compliance.<br><br>Completion date: 01/02/2015 | 1/2/15 |

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| F 441 | Continued From page 31<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure the multi-use glucometer (used to measure blood glucose) was disinfected according to acceptable standards to minimize the potential spread of infection for 6 of 6 residents (R187, R80, R183, R185, R192, R193) who utilized a shared glucometer.<br><br>Findings include:<br><br>The multi-use glucometer was not disinfected in accordance with acceptable standards and facility policy between residents' use.<br><br>R80's blood glucose was checked on 11/20/14 at 7:35 a.m. by a registered nurse (RN)-A. RN-A completed the task, left the room and returned to the medication cart. A disposable cloth was then removed from a container labeled PDI Sani-Hands ALC Antimicrobial Alcohol Gel Hand Wipes. RN-A explained she used the wipes when she was "in a bind," assuming it was acceptable since they were located in the bin containing blood glucose equipment. RN-A reported both Sani Hands and Super Sani Cloth Germicidal Disposable Wipes) killed germs, and the only difference was that Sani Hands contained aloe vera and was more gentle on the skin.<br><br>R187's blood glucose was then checked using the same glucometer on 11/20/14, at 7:45 a.m. | F 441 | | |

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| F 441 | Continued From page 32<br>RN-A identified the resident and explained the procedure. Just prior to utilizing the glucomter, the surveyor stopped the procedure and informed the nurse the germicidal wipes should have been used. RN-A stated she had been in "a hurry" and "used her best judgement."<br><br>RN-C reported on 11/20/14, at 8:10 a.m. staff had been directed to always use the Super Sani Cloth Germicidal Disposable Wipes to clean glucometers between resident use, and were instructed that Sani Wipes were ineffective in disinfecting glucometers. RN-C further explained staff was trained on this practice upon hire and annually regarding blood borne pathogens and minimizing the spread of infection.<br><br>The director of nursing (DON) was interviewed on 11/20/14, at 3:00 p.m. The DON reported the expectation was for staff to clean glucometers with an appropriate germicidal agent as dictated in the facility's policy. She said her understanding was the Sani Hands wipes were ineffective in disinfecting glucometers, and staff had not been trained to use them for that purpose.<br><br>The 3/19/12, Elim Care, Inc. Glucose Meter Disinfection policy directed staff to use "an EPA [Environmental Protection Agency] approved disinfectant" to disinfect glucometers, and to disinfect after each use. "Disinfect the blood glucose meter: remove EPA approved disinfectant wipe from container, wipe the meter down, allow to completely dry to mitigate HIV [human immunodeficiency virus] and other viruses and bacteria before doing the next blood glucose check."<br><br>The Sani Hands Material Data Safety Sheet | F 441 | | |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 441 | Continued From page 33<br>dated 11/29/07, identified the product as an antimicrobial agent with alcohol 60-80% the only listed active ingredient. The Centers for Disease Control and Prevention website warned, "Cleaning and disinfection of blood glucose meters between shared resident uses can prevent transmission of the viruses through indirect contact...Super Sani Cloth is an EPA registered disinfectant...." | F 441 | | |
| F 465 SS=F | 483.70(h)<br>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to maintain the building in a clean and sanitary manner and in good repair. This potentially affected all residents residing in the building.<br><br>Findings include:<br><br>On 11/18/14, at 12:00 p.m. an initial tour of the facility was conducted. Chipped paint was noted on resident doorway frames, facility elevators, and spa room doorways doorway frames. In addition, black marks were observed on the hallway walls throughout the building.<br><br>An environmental tour was conducted with the maintenance/housekeeping director on 11/21/14, at 8:00 a.m. The director verified the condition of | F 465 | **F465**<br>It is the practice of the facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.<br>The facility's position is that the narrative relating to R173, fails to capture the set of circumstances leading up to incident and the actual diminutive amount of residue. The spa was cleaned immediately. Spas and tubs will be cleaned daily and prn by housekeeping. Housekeeping staff re-educated on cleaning schedule of Spas including tubs not in use. The minor doorway nicks and wall marks have been repaired. Preventative maintenance schedule is established and random audits will be completed to ensure compliance and will be reviewed routinely by the QA team to determine frequency and duration of audits.<br>Environmental Services Director responsible for compliance.<br>Completion 01/02/2015 | 1/2/15 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245520 | A. BUILDING _____ B. WING _____ | 11/24/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 465 | Continued From page 34<br>the doorways throughout the building, and said they were in need of repair. The director reported the facility did not utilize a preventive maintenance plan to identify when resident rooms or common areas needed repairs or cleaning. Instead, painting was performed when it was needed, and the painting was not scheduled.<br><br>The spa room on first floor was not kept clean and ready for residents' use.<br><br>On 11/20/14, 11:45 a.m. R173 asked surveyor to observe the shower/bath room. The tub in the spa room was not clean or ready for use. There was loose dust and debris on the bottom of the tub as well as towels and miscellaneous pieces of equipment. R173 reported she had just finished showering and was "giving herself a panic attack" because she had stepped in feces that was smeared on the shower room floor. The toilet area of the spa room was immediately observed with the resident. A brown smear and other loose debris was visible on floor by the toilet. R173 said she used the toilet, but had not seen the feces until after she had stepped in it. A registered nurse (RN)-A was immediately notified of the incident and observed the toilet area. RN-A verified the presence of the fecal smear on the floor, as well as the debris around the toilet. RN-A said, "It looks like someone was eating in here." She donned gloves and used a cleansing cloth to perform preliminary cleaning, and said she would call housekeeping staff so a thorough cleaning could be performed.<br><br>The maintenance director explained in an interview on 11/21/14 at 2:00 p.m. that he was the director of the maintenance, housekeeping and laundry departments. The facility did not employ | F 465 | | |

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|---|---|---|---|
| | 245520 | A. BUILDING _____ B. WING _____ | 11/24/2014 |

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

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| F 465 | Continued From page 35<br>a housekeeping supervisor. He reported that the bath tub on first floor was in working order. The tub was then viewed and the director verified it was not ready for use since it was unclean and miscellaneous items were being stored in the tub.<br><br>On 11/24/14, 11:06 a.m. the maintenance director reported the third and first floor tubs on the west side were in working order. The west third floor tub was observed with the maintenance director. The tub was not in a clean condition, ready for use. There was loose debris including a cotton ball, red and brown colored drips and stains. Dark scuff marks were also present on the interior of tub.<br><br>Facility policies and procedures related to cleaning and maintenance of the facility was requested, but was not provided. | F 465 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245520 | A. BUILDING **01 - BUILDING 01**<br>B. WING _____ | **11/25/2014** |

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

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| K 000 | INITIAL COMMENTS<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on November 25, 2014. At the time of this survey, Redeemer Residence was found in 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.<br><br>Redeemer Residence is a 3-story building with a full basement. The building was constructed at 3 different times. The original 3 story building was constructed in 1960 and was determined to be of Type II(222) construction. In 1975, a 3 story addition was constructed to the South that was determined to be of Type II(222) construction. In 1995, a 3 story addition was constructed to the East that was determined to be of Type II(222) construction. Because the original building and the 2 additions are of the same type of construction, the facility was surveyed as one building.<br><br>This building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 129 beds and had a census of 129 at the time of the survey. | 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.