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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Z4EN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00993

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **7/19/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **212** (L18)
13.Total Certified Beds **212** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Glenora Souther, HFE NE II 07/22/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 07/25/2016 (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
03/31/1974
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 24E116

July 25, 2016

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

Dear Mrs. Foy:

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

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

Effective July 12, 2016 the above facility is certified for:

212 Nursing Facility II 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,

Kamala Fiske-Downing

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 22, 2016

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

RE: Project Number SE116025

Dear Mrs. Foy:

On June 15, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard extended survey, completed on June 2, 2016 that included an investigation of complaint number . This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On July 19, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 2, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 12, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 2, 2016, effective July 19, 2016 and therefore remedies outlined in our letter to you dated June 15, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
24E116		7/19/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 07/19/2016	ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 07/19/2016	ID Prefix F0428 Reg. # 483.60(c) LSC	Correction Completed 07/19/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	7/22/2016	18623	7/19/20/16
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/2/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: Z4EN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00993

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/02/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **10** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **212** (L18)
13.Total Certified Beds **212** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Glenora Souther, HFE NE II — 06/22/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Health Program Representative 07/22/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
7-22-16 (L33)

DETERMINATION APPROVAL

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

020499

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Z4EN

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Facility ID: 00993

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3. Termination	**4. CHOW**
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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

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From (a) :
To (b) :

12.Total Facility Beds **212** (L18)
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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
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___ 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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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1861 (e) (1) or 1861 (j) (1): (L15)

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17. SURVEYOR SIGNATURE Date :
Glenora Souther, HFE NE II 06/22/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 07/22/2016 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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____ 2. Facility is not Eligible
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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
03/31/1974
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 15, 2016

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

RE: Project Number SE116025

Dear Mrs. Foy:

On June 2, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 **Fax: (651) 215-9697**

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 12, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions

are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that

substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 2, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 2, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E116	A. BUILDING _____ B. WING _____	06/02/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a follow up with the physician regarding lab for 2 of the 5 residents (R91, R75) according to the plan of care. Findings include: R91's undated Record of Admission indicated R91's diagnoses included, hypertension, schizoaffective disorder (a mental disorder characterized by abnormal thought processes and deregulated emotions) and diabetes mellitus.	F 282	483.20 Services By Qualified Persons/Per Care Plan How will corrective action be accomplished for resident identified as being affected? Both R 91 and R75 physicians respectively were contacted and where recommendations for subsequent follow up were made, the follow-up has been conducted. How you will identify other resident with	7/12/16

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

Electronically Signed | 06/22/2016

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F 282	Continued From page 1 Review of R91's physician orders revealed R91 had an order for lab test for Hemoglobin A1c (HbA1c-a test that measures an average blood sugar control over a three month period) to be done every three months. Review of R91's medical record revealed R91 had lab tests done for HbA1c as follows: - On 8/7/15, HbA1c lab test with a result of 6.7 % (normal 4.0 to 6.0 %) with an estimated blood glucose average of 146. With a notation indicating lab results were faxed to physician. - On 10/15/15, HbA1c lab test with a result of 7.4 % with an estimated average blood glucose of 166. With a notation indicating lab results were faxed to physician. - On 1/7/16, HbA1c lab test with a result of 7.9 % with an estimated average blood glucose of 180. With a notation indicating lab results were faxed to physician. - On 5/5/16, HbA1c lab test with a result of 8.0 % with an estimated average blood glucose of 183. With a notation indicating lab results were faxed to physician. Review of R91's medical record revealed a Nutritional Assessment dated 4/8/16, the assessment indicated R91's diabetes mellitus was "...considered poorly controlled..." and made recommendation to consult primary physician regarding elevated HbA1c lab results and "PMD [primary medical doctor] to consider increasing Metformin [medication used in the management of diabetes] dose to 750mg [milligrams] BID [twice a day]." R91's medical record was reviewed and revealed that R91 had a scheduled medical appointment with his primary physician on 3/24/16, 4/12/16, and 5/16/16, which R91 declined to attend. The	F 282	the potential of being affected by the practice The Director of Nursing and/or designee will complete audits of lab values for all potentially affected residents. Any potentially identified issues will be corrected. This audit and any subsequent follow-up will be completed by 07/12/2016. Measure put in place to ensure deficient practice will not recur Nursing staff will be provided with education by the Director of Nursing and/or designee on the protocol for monitoring labs, review of nutritional assessments and follow-up communication with appropriate health care providers. This will be completed on or before 07/12/2016. How will the plan be monitored to ensure the solutions are sustained? Ongoing Monthly Audits for the identified issues will be conducted by the Director of Nursing and/or designee. The findings of the audit will be reported to the Quality Assurance Committee each quarterly meeting.	

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F 282	Continued From page 2	F 282		

record lacked evidence of contacting primary physician to discuss elevated HbA1c lab results and nutritional assessment recommendations after R91 declined to attend the appointments.

The undated current plan for R91's diabetes noted staff were to consult with the healthcare providers as scheduled and as needed. R91 did not have the HbA1c lab results and nutritional assessment recommendations followed up on accrdoing to the plan of care.

During a joint interview on 6/2/16, at 11:31 a.m. with registered nurse (RN)-A and RN-B both acknowledged that R91 had declined to attend his medical appointment in March, April and May 2016. RN-A and RN-B both verified nursing staff did not contact primary physician to discuss elevated HbA1c lab results and nutritional assessment recommendations after R91's missed May appointment.

On 6/2/16, at 12:48 p.m. the facility's director of nursing (DON) stated the expectation was nursing staff to review the lab results and compare with previous results and if abnormal communicate with the provider either by phone or make an appointment for resident to be seen in clinic. DON verified nursing staff did not attempt to communicate with provider regarding elevated HbA1c lab results after R91's missed appointments.

The Andrew Residence's lab policy titled "LABORATORY RESULTS PROTOCOL" dated 8/18/08, indicated that lab results will be reviewed by the facility's nurse and the nurse will document on the lab report any action that was taken. The protocol further directed all abnormal results will

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F 282	Continued From page 3 be compared with prior results and the physician will be notified. R75's care plan was not followed for obtaining lithium levels every three months per the plan of care. R75's record of admission sheet with admit date 8/11/04. R75's current Physician Order sheet with diagnoses which included disorganized schizophrenia, extrapyramidal and movement disorder, hypothyroidism, hyperlipidemia and generalized anxiety disorder. Furthermore, R75 had an order for lithium carbonate 300 milligrams (mg) by mouth in morning and 600 mg by mouth at bedtime for Schizophrenia. "Lithium level Q [every] 3mo [three months] ..." The lithium level was obtained on 7/16/15, 10/8/15, and 1/26/16, however, the medical record lacked evidence of the lithium level being drawn in April of 2016 and R75 had an order to draw lithium on 6/14/16. R75's care plan dated 2/14/16, noted R75 had interventions to minimize/prevent involuntary movement. The interventions were to administer medications per physician (MD), Cogentin (used to treat Parkinson's disease and drug-induced extrapyramidal disorders) as scheduled and as needed, monitor for medication side effects biannually using the MOSES and DISCUS tool and consult with MD as scheduled and as needed. However, R75's medical record lacked documentation of monitoring the lithium carbonate level been obtain since 1/26/16, and lacked evidence that the facility consulted the physician for the missed lithium lab work.	F 282		

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F 282	Continued From page 4 The MAR (Medication Administration Record) for January 2016, February 2016, March 2016, April 2016 and May 2016, indicated R75 received Lithium 300 mg by mouth twice times a day. In addition, MAR identified, R75 received Lithium carbonate 300 mg by mouth in morning and 600 mg by mouth at bedtime. MAR for June 2016 indicated R75 had diagnosis of Schizophrenia and anxiety. On 6/2/16, at 11:04 a.m. registered nurse (RN)-Z verified R75's medical record lacked documentation of lithium level checked since 1/26/16, and stated R75 had orders for lithium level to be checked every three months and her expectation was staff need to carry the order out. On 6/2/16 at 2:33 p.m. director of nursing reviewed the care plan and verified the care plan lacked lithium carbonate medication and indicated, was unable to find lithium carbonate medication in the care plan.	F 282		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents	F 329		7/12/16

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F 329	Continued From page 5 who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adequate monitoring was conducted for irregularities, and failed to ensure the physician was notified of irregularities for 2 of the 5 residents (R91, R75) reviewed for unneccessary medications. Findings include: R91's undated Record of Admission indicated R91's diagnoses included, hypertension, schizoaffective disorder (a mental disorder characterized by abnormal thought processes and deregulated emotions) and diabetes mellitus. Review of R91's physician orders revealed R91 had an order for lab test for Hemoglobin A1c (HbA1c-a test that measures an average blood sugar control over a three month period) to be done every three months. Review of R91's medical record revealed R91 had lab tests done for HbA1c as follows;	F 329	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS How will corrective action be accomplished for resident identified as being affected? Both R 91 and R75 physicians respectively were contacted and where recommendations for subsequent follow up were made the follow-up has been conducted. How you will identify other resident with the potential of being affected by the practice The Director of Nursing and/or designee will complete audits of lab values for all potentially affected residents. Any potentially identified issues will be corrected. This audit and any subsequent follow-up will be completed by 07/12/2016.	

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F 329	Continued From page 6 - On 8/7/15, HbA1c lab test with a result of 6.7 % (normal 4.0 to 6.0 %) with an estimated blood glucose average of 146. With a notation indicating lab results were faxed to physician. - On 10/15/15, HbA1c lab test with a result of 7.4 % with an estimated average blood glucose of 166. With a notation indicating lab results were faxed to physician. - On 1/7/16, HbA1c lab test with a result of 7.9 % with an estimated average blood glucose of 180. With a notation indicating lab results were faxed to physician. - On 5/5/16, HbA1c lab test with a result of 8.0 % with an estimated average blood glucose of 183. With a notation indicating lab results were faxed to physician. Review of R91's medical record revealed a Nutritional Assessment dated 4/8/16, the assessment indicated R91's diabetes mellitus was "...considered poorly controlled..." and made recommendation to consult primary physician regarding elevated HbA1c lab results and "PMD [primary medical doctor] to consider increasing Metformin [medication used in the management of diabetes] dose to 750mg [milligrams] BID [twice a day]." R91's medical record was reviewed and revealed R91 had a scheduled medical appointment with his primary physician on 3/24/16, 4/12/16, and 5/16/16, which R91 declined to attend. The record lacked evidence of contacting primary physician to discuss elevated HgA1c lab results and nutritional assessment recommendations after R91 declined to attend the appointments. Review of the consultant pharmacist reports indicated R91's medication monitoring did not have any irregularities by the consultant	F 329	Measure put in place to ensure deficient practice will not recur Nursing staff will be provided with education by the Director of Nursing and/or designee on the protocol for monitoring labs, review nutrition assessments and follow-up communication with appropriate health care providers. This will be completed on or before 07/12/2016. How will the plan be monitored to ensure the solutions are sustained? Ongoing Monthly Audits for the identified issues will be conducted by the Director of Nursing and/or designee. The findings of the audit will be reported to the Quality Assurance Committee each quarterly meeting.	

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F 329	Continued From page 7 pharmacist during the monthly reviews. During a joint interview on 6/2/16, at 11:31 a.m. with registered nurse (RN)-A and RN-B both acknowledged that R91 had declined to attend his medical appointment in March, April and May 2016. RN-A and RN-B both verified nursing staff did not contact primary physician to discuss elevated HbA1c lab results and nutritional assessment recommendations after R91's missed May 2016 appointment. On 6/2/16, at 12:48 p.m. the facility's director of nursing (DON) stated the expectation was nursing staff to review the lab results and compare with previous results and if abnormal communicate with the provider either by phone or make an appointment for resident to be seen in clinic. DON verified that nursing staff did not attempt to communicate with provider regarding elevated HbA1c lab results after R91's missed appointments. The Andrew Residence's lab policy titled "LABORATORY RESULTS PROTOCOL" dated 8/18/08, indicated lab results will be reviewed by the facility's nurse and the nurse will document on the lab report any action that was taken. The protocol further directed all abnormal results will be compared with prior results and the physician will be notified. R75 was observed on 6/2/16, at 9:19 a.m. to be awake and lying in bed. When approached and interviewed regarding the medication, lithium carbonate, R75 indicated he did not notice or experience any side effects from the medication. R75 was observed to be relaxed with no	F 329		

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F 329	Continued From page 8	F 329		

behaviors.

R75's record of admission sheet with admit date 8/11/04. R75's current Physician Order sheet with diagnoses which included disorganized schizophrenia, extrapyramidal and movement disorder, hypothyroidism, hyperlipidemia and generalized anxiety disorder.
Furthermore, R75 had an order for lithium carbonate 300 milligrams (mg) by mouth in morning and 600 mg by mouth at bedtime for Schizophrenia. "Lithium level Q [every] 3mo [three months] ..." The lithium level was obtained on 7/16/15, 10/8/15, and 1/26/16, however, medical record lacked evidence of the lithium level being drawn in April of 2016 and R75 had an order to draw lithium on 6/14/16.

R75's quarterly Minimum Data Set dated 4/21/16, indicated R75 had an antipsychotic, antidepressant and antianxiety medications within the last seven days within the last seven days.

The MAR (Medication Administration Record) for January 2016, February 2016, March 2016, April 2016 and May 2016, indicated R75 received lithium 300 mg by mouth twice times a day. In addition, MARs identified, R75 received Lithium carbonate 300 mg by mouth in morning and 600 mg by mouth at bedtime.

R75's care plan dated 2/14/16, noted R75 had interventions to minimize/prevent involuntary movement. The interventions were to administer medications per physician (MD), Cogentin (used to treat Parkinson's disease and drug-induced extrapyramidal disorders) as scheduled and as needed, monitor for medication side effects biannually using the MOSES and DISCUS tool

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F 329	Continued From page 9	F 329		

and consult with MD as scheduled and as needed. However, R75's medical record lacked documentation of monitoring the lithium carbonate level been obtain since 1/26/16.

On 6/2/16, at 11:04 a.m. registered nurse (RN)-Z verified R75's medical record lacked documentation of lithium level checked since 1/26/16, and stated R75 had orders for lithium level to be checked every three months and her expectation was staff needed to carry the order out.

On 6/2/16, at 11:52 a.m. director of nursing (DON) reviewed R75 medical record and confirmed the medical record lacked lithium level done since 1/26/16, and stated another lithium lab level should have been done in April 2016. It was her expectation that there would have been reconciliation from month to month and staff was to anticipate the lab work and if there was something missing, they should have notified the medical provider, so the error could be corrected. In addition, the DON indicated "our consultant pharmacist would include this type medication regimen in her medication regimen review."

On 6/2/16 at 2:29 p.m. the consultant pharmacist (PC), stated, when a resident is on the lithium medication, lithium level should be monitor, but if resident labs are stable, "no" but if the medical provider ordered it, "Yes." In addition, CP indicated, she did not review resident lithium levels because she did not check the resident lithium level every three months.

The Andrew Residence's policy titled "MONTHLY MEDICATION REGIME REVIEWS" dated 3/27/00, directed the pharmacist to review each

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F 329	Continued From page 10 resident's medication regime on a monthly basis and prepare a drug regime review summary with irregularities found. The policy indicated the pharmacist to review resident's laboratory findings, dietary considerations, concerns related to dosing and combination of medications. Neither the facility nor the CP noted R75's lithium lab level was not obtained per the MD's Order.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure the consultant pharmacist identified medication monitoring irregularities for 1 of the 5 residents (R91) reviewed for unneccessary medications monitoring. Findings include: R91's undated Record of Admission indicated R91's diagnoses included, hypertension, schizoaffective disorder (a mental disorder characterized by abnormal thought processes and deregulated emotions) and diabetes mellitus.	F 428	F483 Drug Regimen Review, Report Irregular, act on How will corrective action be accomplished for resident identified as being affected? It is the policy of Andrew Residence to ensure that the pharmacist reviews each drug regimen on a monthly basis. R91 medications have been reassessed by the pharmacist and physician. How you will identify other resident with the potential of being affected by the	7/12/16

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F 428	Continued From page 11 Review of R91's physician orders revealed R91 had an order for lab test for Hemoglobin A1c (HbA1c-a test that measures an average blood sugar control over a three month period) to be done every three months. Review of R91's medical record revealed R91 had lab tests done for HbA1c as follows; - On 8/7/15, HbA1c lab test with a result of 6.7 % (normal 4.0 to 6.0 %) with an estimated blood glucose average of 146. With a notation indicating lab results were faxed to physician. - On 10/15/15, HbA1c lab test with a result of 7.4 % with an estimated average blood glucose of 166. With a notation indicating lab results were faxed to physician. - On 1/7/16, HbA1c lab test with a result of 7.9 % with an estimated average blood glucose of 180. With a notation indicating lab results were faxed to physician. - On 5/5/16, HbA1c lab test with a result of 8.0 % with an estimated average blood glucose of 183. With a notation indicating lab results were faxed to physician. Review of R91's medical record revealed a Nutritional Assessment dated 4/8/16, the assessment indicated R91's diabetes mellitus was "...considered poorly controlled..." and made recommendation to consult primary physician regarding elevated HbA1c lab results and "PMD [primary medical doctor] to consider increasing Metformin [medication used in the management of diabetes] dose to 750mg [milligrams] BID [twice a day]." R91's medical record was reviewed and revealed R91 had a scheduled medical appointment with	F 428	practice The Director of Nursing and/or designee will complete audits of lab values for all potentially affected residents. Any potentially identified issues will be corrected. This audit and any subsequent follow-up will be completed by 07/12/2016. Measure put in place to ensure deficient practice will not recur Nursing staff will be provided with education by the Director of Nursing and/or designee on the protocol for following consultant pharmacists□ reviews and recommendations. A monthly quality assurance evaluation has been implemented under the supervision of the QA committee. This evaluation will include a systematic review of residents with lab orders and a review of pharmacy consultation forms to ensure identified issues are being addressed. How will the plan be monitored to ensure the solutions are sustained? The evaluation results will be forwarded to the Quality Assurance committee by the Director of Nursing or designee. The committee will assess completeness and potential need for modifications in the process used by the consulting pharmacist.	

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F 428	Continued From page 12	F 428		

his primary physician on 3/24/16, 4/12/16, and 5/16/16, which R91 declined to attend. The record lacked evidence of contacting primary physician to discuss elevated HgA1c lab results and nutritional assessment recommendations after R91 declined to attend the appointments. Review of the consultant pharmacist reports indicated R91's medication monitoring did not have any irregularities by the consultant pharmacist during the monthly reviews.

During a joint interview on 6/2/16, at 11:31 a.m. with registered nurse (RN)-A and RN-B both acknowledged that R91 had declined to attend his medical appointment in March, April and May 2016. RN-A and RN-B both verified nursing staff did not contact primary physician to discuss elevated HbA1c lab results and nutritional assessment recommendations after R91's missed May 2016 appointment.

On 6/2/16, at 12:48 p.m. the facility's director of nursing (DON) stated the expectation is nursing staff to review the lab results and compare with previous results and if abnormal communicate with the provider either by phone or make an appointment for resident to be seen in clinic. DON verified that nursing staff did not attempt to communicate with provider regarding elevated HbA1c lab results after R91's missed appointments.

During interview on 6/2/16, at 2:07 p.m. the facility's consulting pharmacist (CP) verified she does the monthly drug regimen reviews for all residents in the facility, the CP stated part of the drug reviews involves reviewing residents' lab results. CP stated no drug monitoring irregularities were identified for R91 during the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E116	A. BUILDING _____ B. WING _____	06/02/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 13 monthly drug regimen reviews. When asked about the HbA1c lab results for R91, CP stated HbA1c lab results were increasing and should have been communicated to the provider. CP acknowledged that she should have identified the increase in the HbA1c during the monthly drug regimen reviews and made recommendations for follow up with primary physician. The Andrew Residence's policy titled "MONTHLY MEDICATION REGIME REVIEWS" dated 3/27/00, directed the pharmacist to review each resident's medication regime on a monthly basis and prepare a drug regime review summary with irregularities found. The policy indicated the pharmacist to review resident's laboratory findings, dietary considerations, concerns related to dosing and combination of medications.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E116	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/02/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on June 02, 2016. At the time of this survey, Andrew 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. Andrew Residence is a 5-story building with a basement. The building was constructed in 1973, with an addition in 1978 and was determined to be of Type II(222) construction. Each floor of the facility is divided into 2 smoke zones by 30 minute fire barriers. The entire building is protected with a complete automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a fire alarm system with corridor smoke detection and in common areas that are on the fire alarm system. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 212 beds and had a census of 212 at the time of the survey. The facility was surveyed as one building. At this time, the conditions of 42 CFR, Subpart	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E116	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/02/2016**

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

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K 000	Continued From page 1 483.70(a) is MET.	K 000		