DEPARTMENT OF	F HEALTH A	ND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDI	CAID SERVICES
						AND TRANSMITTAL		ID: Z4EN
		PART I -	TO BE COMP	LETED BY T	THE STAT	TE SURVEY AGENCY		Facility ID: 00993
1. MEDICARE/MEDICA (L1) <b>24E116</b>	ID PROVIDER N	0.	3. NAME AND A (L3) ANDREW I		CILITY		4. TYPE OF ACTI	ON: $\underline{7}(L8)$
(L1) <b>24E116</b> 2.STATE VENDOR OR M	/FDICAID NO		(L4) <b>1215 SOUT</b>		т		1. Initial	2. Recertification
(L2) <b>201955800</b>	ildicitid no.		(L5) MINNEAPO			(L6) <b>55404</b>	3. Termination 5. Validation	4. CHOW 6. Complaint
5. EFFECTIVE DATE CH	HANGE OF OWN	IERSHIP	7. PROVIDER/SU			<u>10</u> (L7)	7. On-Site Visit 8. Full Survey Aft	9. Other er Complaint
(L9)			01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	0. Fui Sui vey Ait	
6. DATE OF SURVEY		<b>)16</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR END	DING DATE: (L35)
8. ACCREDITATION ST		(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID		12/31	
0 Unaccredited 2 AOA	1 TJC 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/51	
11LTC PERIOD OF CEF	RTIFICATION		10.THE FACILIT		AS:			
From (a):			X A. In Complia			And/Or Approved Waivers Of	<b>U</b> 1	
To (b) :				equirements e Based On:		2. Technical Personnel		
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12. Total Facility Beds	2	212 (L18)	1. <i>P</i>			4. 7-Day KN (Kulai SP	9. Beds/Roo	
13.Total Certified Beds	2	<b>212</b> (L17)	-	pliance with Progra		5. Life Safety Code		11
			Requirements	s and/or Applied V	Waivers:	* Code: A	(L12)	
14. LTC CERTIFIED BED						15. FACILITY MEETS		
18 SNF	18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
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(L37)	(L38)	(L39)	(L42)	(L43)				
17. SURVEYOR SIGNAT	ΓURE		Date :			18. STATE SURVEY AGENCY	Z APPROVAL	Date:
Glenora S	outher, HFE	NE II	(	07/22/2016	(L19)	Kamala Fiske-Downing. Hea	alth Program Repres	entative <sup>07/25/2016</sup> (L20)
	PART I	II - TO BE (	COMPLETED	BY HCFA RE	GIONAI	OFFICE OR SINGLE S	STATE AGENCY	(220)
19. DETERMINATION (	OF ELIGIBILITY		20. COM	MPLIANCE WITH	I CIVIL	21. 1. Statement of Fina	ncial Solvency (HCFA-25	572)
1. Facility is	s Eligible to Partici	inate	RIG	HTS ACT:		<ol> <li>Ownership/Control</li> <li>Both of the Above</li> </ol>	ol Interest Disclosure Str	nt (HCFA-1513)
-	is not Eligible	ipute				5. Dour of the Above		
	5	(L21)						
22. ORIGINAL DATE	23	. LTC AGREEN	MENT 2	4. LTC AGREEN	IENT	26. TERMINATION ACTION	:	(L30)
OF PARTICIPATION	1	BEGINNING	DATE	ENDING DAT	ГЕ	VOLUNTARY 00	<u>INVOLU</u>	JNTARY_
03/31/1974						01-Merger, Closure		Meet Health/Safety
(L24)		(L41)		(L25)		02-Dissatisfaction W/ Reimburs		Meet Agreement
25. LTC EXTENSION D	DATE: 27	. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	OTHER	
		A. Suspension	n of Admissions:	~		04-Other Reason for Withdrawal		der Status Change
	(L27)	B Rescind Su	spension Date:	(L44)			00-Activ	e
		D. Resente St	ispension Date.	(L45)				
28. TERMINATION DAT	ſE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS		
		(7.00)						
		(L28)			(L31)			
31. RO RECEIPT OF CM	S-1539	32	. DETERMINATION	N OF APPROVAL	DATE			



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,

Kumala Fiske Downing

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



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,

Kumalu Fiske Downing

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

### **POST-CERTIFICATION REVISIT REPORT**

	MULTIPLE CONSTRUCTION			DATE OF REVIS	IT
IDENTIFICATION NUMBER	A. Building				
24E116 <sub>Y1</sub>	B. Wing	Y	′2	7/19/2016	Y3
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	DATE	ITEM	DATE	ITEM		DATE
Y4	Y5	Y4	Y5	Y4		Y5
ID Prefix F0282 483.20(k)(3)(ii)	Correction	ID Prefix F0329	5(1)	ID Prefix	F0428 483.60(c)	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	400.00(0)	Completed
LSC	07/19/2016		07/19/2016	LSC		07/19/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC				LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		LSC		_
REVIEWED BY		DATE	SIGNATURE OF SURVEYOR	1	DATE	E
STATE AGENCY	(INITIALS) GD/kfd	7/22/2016	18	623	7/	/19/20/16
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE		DATE	E
FOLLOWUP TO SURVEY COMPLETED ON 6/2/2016			R ANY UNCORRECTED DEFICIEN CTED DEFICIENCIES (CMS-2567)	NCIES. WAS SENT TO TH		YES 🗌 NO

DEPARTMENT O	F HEALTI	H AND HUMA	N SERVICES			CENTERS FOR ME	DICARE & MEDICAID SERVICES
						AND TRANSMITTAL	ID: Z4EN
		PART I -	TO BE COMPI	LETED BY 1	THE STA	TE SURVEY AGENCY	Facility ID: 00993
1. MEDICARE/MEDICA	AID PROVIDE	ER NO.	3. NAME AND AI (L3) ANDREW F		CILITY		4. TYPE OF ACTION: <u>2(</u> L8)
(L1) <b>24E116</b> 2.STATE VENDOR OR I		10	(L3) ANDREW F		r Tr		1. Initial 2. Recertification
(L2) 201955800	MEDICAIDN	10.	(L4) 1213 SOUT		51	(L6) 55404	3. Termination 4. CHOW 5. Validation 6. Complaint
							7. On-Site Visit 9. Other
<ol> <li>5. EFFECTIVE DATE C (L9)</li> </ol>	MANGE OF C	JWNERSHIP	7. PROVIDER/SU	05 HHA	JORY 09 E\$RD	<u>10</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY	0.00	a (a 0.1 al 34)	01 Hospital 02 SNF/NF/Dual	05 HHA 06 PRTF	10 NF		
8. ACCREDITATION S		<b>)2/2016</b> <sup>(L34)</sup> (L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/III	14 CORF 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 2 AOA	1 TJC 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
11. LTC PERIOD OF CE		J .	10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		•	A. In Complia			And/Or Approved Waivers Of	The Following Requirements:
To (b) :				equirements		2. Technical Personnel	
· ·			Compliance	e Based On:		3. 24 Hour RN	7. Medical Director
12 Tetal Escility Dada		212 (119)	1. A	cceptable POC		4. 7-Day RN (Rural Si	NF) 8. Patient Room Size
12.Total Facility Beds 13.Total Certified Beds		212 (L18) 212 (L17)	X B. Not in Con	u-lian an mish Dua		5. Life Safety Code	9. Beds/Room
15. Total Certified beds		212 (L17)		and/or Applied <sup>1</sup>	-	* Code: B*	(L12)
14. LTC CERTIFIED BE	D BREAKDO	WN				15. FACILITY MEETS	
18 SNF	18/19 SNF	19 SNF	ICF	Ш		1861 (e) (1) or 1861 (j) (1):	(L15)
		212					
(L37)	(L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AC	ENCY REM	ARKS (IF APPLICA	BLE SHOW ETC CA	INCELLATION .	DATE):		
17. SURVEYOR SIGNA	TURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Glenora S	Souther, HI	FE NE II		6/22/2016	(L19)	K <u>amala Fiske-Downing. Hea</u>	alth Program Representative 07/22/2016 (L20
	PAF	RT II - TO BE (	COMPLETED I	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE S	TATE AGENCY
19, DETERMINATION	OF ELIGIBIL	ITY		IPLIANCE WITI	H CIVIL		ncial Solvency (HCFA-2572)
X 1 Facility i	is Eligible to Pi	artícioate	RIGH	ITS ACT:		<ol> <li>Ownership/Contr</li> <li>Both of the Abov</li> </ol>	ol Interest Disclosure Stmt (HCFA-1513)
	is not Eligible					5. Dour of the root	
		(L21)					
22. ORIGINAL DATE		23. LTC AGREEN	AENT 24	4. LTC AGREEN	ÆNT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATIO	N	BEGINNING	DATE	ENDING DA	TE	VOLUNTARY 0	<u>INVOLUNTARY</u>
03/31/1974						01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)		(L41)		(L25)		02-Dissatisfaction W/ Reimburs	ement 06-Fail to Meet Agreement
25. LTC EXTENSION I	DATE:	27. ALTERNATI	VE SANCTIONS	. ,		03-Risk of Involuntary Termination	on <u>OTHER</u>
		A. Suspension	of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
	(1.04)			(L <b>4</b> 4)			00-Active
	(L27)	B. Rescind Su	spension Date:				
				(LA5)			
28. TERMINATION DA	JE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS	
		(L28)			(L31)		
	(0.1520		DETEDIATIO		DATE		
31. RO RECEIPT OF CM	13 <b>-</b> 1337		DETERMINATION $\eta - 22 - 1$				
		(L32)		1.40	(L33)	DETERMINATION APP	KUVAL YON YOU

DEPARTMENT O	F HEALTH	HAND HUMA	N SERVICES			<b>CENTERS FOR MEI</b>	DICARE & MEDICAID SERVICES
		MEDICA	ARE/MEDICAL	D CERTIFIC	ATION A	AND TRANSMITTAL	ID: Z4EN
		PART I -	TO BE COMPI	LETED BY T	HE STAT	TE SURVEY AGENCY	Facility ID: 00993
1. MEDICARE/MEDICA (L1) <b>24E116</b>	AID PROVIDE	R NO.	3. NAME AND AI (L3) <b>ANDREW R</b>		ILITY		<ol> <li>TYPE OF ACTION: <u>2</u>(L8)</li> <li>Initial 2. Recertification</li> </ol>
2.STATE VENDOR OR M (L2) 201955800	MEDICAID N	0.	(L4) <b>1215 SOUTI</b> (L5) <b>MINNEAPC</b>		Т	(L6) <b>55404</b>	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE C	HANGE OF C	WNERSHIP	7. PROVIDER/SU	JPPLIER CATEG	ORY	<u>10</u> (L7)	7. On-Site Visit 9. Other
(L9)			01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY	06/0	<b>2/2016</b> <sup>(L34)</sup>	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
8. ACCREDITATION ST	TATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 2 AOA	1 TJC 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
11LTC PERIOD OF CE	RTIFICATION	[	10.THE FACILITY	IS CERTIFIED	AS:		
From (a):			A. In Complia	ince With		And/Or Approved Waivers Of	The Following Requirements:
To (b) :				equirements		2. Technical Personnel	6. Scope of Services Limit
				e Based On:		3. 24 Hour RN	7. Medical Director
12. Total Facility Beds		<b>212</b> (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	
13.Total Certified Beds		<b>212</b> (L17)	X B. Not in Con	npliance with Prog	ram	5. Life Safety Code	9. Beds/Room
				and/or Applied W		* Code: <b>B</b> *	(L12)
14. LTC CERTIFIED BEI	D BREAKDO	WN				15. FACILITY MEETS	
18 SNF	18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
		212					
(L37)	(L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AG	ENCY REMA	ARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION I	DATE):		
					<i>y</i> -		
17. SURVEYOR SIGNA	TURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Glenora S	Souther, HF	E NE II	0	6/22/2016	(L19)	K <u>amala Fiske-Downing. Hea</u>	Ith Program Representative 07/22/2016 (L20)
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19. DETERMINATION	OF ELIGIBILI	ITY	20. COM	IPLIANCE WITH	I CIVIL		ncial Solvency (HCFA-2572)
1. Facility i	is Eligible to P	articipate	RIGH	HTS ACT:		<ol> <li>Ownership/Control</li> <li>Both of the Above</li> </ol>	ol Interest Disclosure Stmt (HCFA-1513)
-	is not Eligible	articipate				5. Bour of the Above	· · · · · · · · · · · · · · · · · · ·
2. 1 uonity	is not Englore	(L21)					
22. ORIGINAL DATE		23. LTC AGREEN	MENT 24	4. LTC AGREEM	IENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	N	BEGINNING	DATE	ENDING DAT	Έ	VOLUNTARY 00	INVOLUNTARY
03/31/1974						01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)		(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ement 06-Fail to Meet Agreement
25. LTC EXTENSION I	DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	n <u>OTHER</u>
						04-Other Reason for Withdrawal	
		A. Suspension	n of Admissions:			04-Other Reason for withdrawar	07-Provider Status Change
	(1.27)	-		(L44)		04-Other Reason for windrawar	07-Provider Status Change 00-Active
	(L27)	-	n of Admissions: Ispension Date:	(L44)		04-Other Reason for whilelawar	-
		B. Rescind Su	spension Date:	(L45)			-
28. TERMINATION DA		B. Rescind Su		(L45)		30. REMARKS	-
28. TERMINATION DA		B. Rescind Su	spension Date:	(L45)	(121)		-
28. TERMINATION DA		B. Rescind Su	spension Date:	(L45)	(L31)		-
28. TERMINATION DA 31. RO RECEIPT OF CM	TE:	B. Rescind St 29 (L28)	spension Date:	(L45) CARRIER NO.			-
	TE:	B. Rescind St 29 (L28)	uspension Date:	(L45) CARRIER NO.			00-Active



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:

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

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

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

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

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

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

#### DEPARTMENT CONTACT

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

Gloria Derfus, 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

Andrew Residence June 15, 2016 Page 3

> 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

Andrew Residence June 15, 2016 Page 4

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.

Andrew Residence June 15, 2016 Page 5

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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

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

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

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

		AND HUMAN SERVICES		FORI	M APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		OMB NO	D. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ATE SURVEY
		24E116	B. WING _		6/02/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				1215 SOUTH 9TH STREET	
ANDREV	/ RESIDENCE			MINNEAPOLIS, MN 55404	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	S	F 00	0	
F 282 SS=D	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of your validate that substar regulations has been your verification. 483.20(k)(3)(ii) SEF PERSONS/PER CA The services provided b	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with RVICES BY QUALIFIED	F 28	2	7/12/16
	by: Based on interview facility failed to ensi physician regarding (R91, R75) accordin Findings include: R91's undated Rec R91's diagnoses in schizoaffective disc characterized by ab	NT is not met as evidenced and document review, the ure a follow up with the lab for 2 of the 5 residents ing to the plan of care.		<ul> <li>483.20 Services By Qualified Persons/Per Care Plan</li> <li>How will corrective action be accomplished for resident identified as being affected?</li> <li>Both R 91 and R75 physicians respectively were contacted and where recommendations for subsequent follow up were made, the follow-up has been conducted.</li> <li>How you will identify other resident with</li> </ul>	
LABORATOR	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE
Electron	ically Signed				06/22/2016

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

PRINTED: 06/22/2016

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 24E116 **B** WING 06/02/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1215 SOUTH 9TH STREET ANDREW RESIDENCE **MINNEAPOLIS, MN 55404** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 282 Continued From page 1 F 282 Review of R91's physician orders revealed R91 the potential of being affected by the had an order for lab test for Hemoglobin A1c practice (HbA1c-a test that measures an average blood The Director of Nursing and/or designee sugar control over a three month period) to be will complete audits of lab values for all potentially affected residents. Any done every three months. potentially identified issues will be Review of R91's medical record revealed R91 corrected. This audit and any subsequent had lab tests done for HbA1c as follows: follow-up will be completed by - On 8/7/15, HbA1c lab test with a result of 6.7 % 07/12/2016. (normal 4.0 to 6.0 %) with an estimated blood glucose average of 146. With a notation Measure put in place to ensure deficient indicating lab results were faxed to physician. practice will not recur - On 10/15/15, HbA1c lab test with a result of 7.4 Nursing staff will be provided with % with an estimated average blood glucose of education by the Director of Nursing 166. With a notation indicating lab results were and/or designee on the protocol for faxed to physician. monitoring labs, review of nutritional assessments and follow-up - On 1/7/16, HbA1c lab test with a result of 7.9 % with an estimated average blood glucose of 180. communication with appropriate health With a notation indicating lab results were faxed care providers. This will be completed on to physician. or before 07/12/2016. - On 5/5/16, HbA1c lab test with a result of 8.0 % with an estimated average blood glucose of 183. How will the plan be monitored to ensure With a notation indicating lab results were faxed the solutions are sustained? Ongoing Monthly Audits for the identified to physician. Review of R91's medical record revealed a issues will be conducted by the Director of Nutritional Assessment dated 4/8/16. the Nursing and/or designee. The findings of assessment indicated R91's diabetes mellitus the audit will be reported to the Quality was "...considered poorly controlled..." and made Assurance Committee each quarterly recommendation to consult primary physician meeting. 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

FORM CMS-2567(02-99) Previous Versions Obsolete

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PRINTED: 06/22/2016

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 06/22/2016 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY IPLETED
		24E116	B. WING	i		06/	02/2016
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
ANDREV	RESIDENCE				1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	physician to discuss and nutritional asse after R91 declined if The undated curren noted staff were to providers as schedu not have the HbA1c assessment recom accrdoing to the pla During a joint interv with registered nurs acknowledged that his medical appoint 2016. RN-A and RN did not contact prim elevated HbA1c lab assessment recom missed May appoint On 6/2/16, at 12:48 nursing (DON) state nursing staff to revi compare with previe communicate with t make an appointme clinic. DON verified to communicate wit HbA1c lab results a appointments. The Andrew Reside "LABORATORY RE 8/18/08, indicated t by the facility's nurs on the lab report an	ence of contacting primary is elevated HbA1c lab results assment recommendations to attend the appointments. It plan for R91's diabetes consult with the healthcare uled and as needed. R91 did to lab results and nutritional mendations followed up on an of care. iew on 6/2/16, at 11:31 a.m. se (RN)-A and RN-B both R91 had declined to attend ment in March, April and May N-B both verified nursing staff hary physician to discuss or results and nutritional mendations after R91's tment. p.m. the facility's director of ed the expectation was ew the lab results and ous results and if abnormal he provider either by phone or ent for resident to be seen in nursing staff did not attempt h provider regarding elevated	F2	282			

If continuation sheet Page 3 of 14

		AND HUMAN SERVICES				FORM	06/22/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY IPLETED
		24E116	B. WING	i		06/	02/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ANDREV	V RESIDENCE				1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	Continued From pa be compared with p will be notified. R75's care plan was lithium levels every care. R75's record of adm 8/11/04. R75's curre diagnoses which in schizophrenia, extra disorder, hypothyro generalized anxiety Furthermore, R75 h carbonate 300 millig morning and 600 m Schizophrenia. "Lith [three months]" on 7/16/15, 10/8/15 medical record lack level being drawn ir order to draw lithium R75's care plan dat interventions to min movement. The inter medications per phy to treat Parkinson's extrapyramidal diso needed, monitor for biannually using the and consult with MI needed. However, I	age 3 prior results and the physician s not followed for obtaining three months per the plan of mission sheet with admit date ent Physician Order sheet with cluded disorganized apyramidal and movement idism, hyperlipidemia and disorder. nad an order for lithium grams (mg) by mouth in ng by mouth at bedtime for nium level Q [every] 3mo The lithium level was obtained b, and 1/26/16, however, the sed evidence of the lithium in April of 2016 and R75 had an	ı	282	DEFICIENCY)		
	carbonate level bee lacked evidence that	en obtain since 1/26/16, and at the facility consulted the issed lithium lab work.					

Facility ID: 00993

If continuation sheet Page 4 of 14

		AND HUMAN SERVICES				FORM	06/22/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		24E116	B. WING			06/	02/2016
NAME OF I	PROVIDER OR SUPPLIER		-		TREET ADDRESS, CITY, STATE, ZIP CODE		
ANDREV	<b>V RESIDENCE</b>				215 SOUTH 9TH STREET /INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 4	F 2	282			
F 329 SS=D	January 2016, Febr 2016 and May 2016 Lithium 300 mg by addition, MAR ident carbonate 300 mg l mg by mouth at bee indicated R75 had o and anxiety. On 6/2/16, at 11:04 verified R75's medi documentation of lit 1/26/16, and stated level to be checked expectation was sta On 6/2/16 at 2:33 p reviewed the care p lacked lithium carbo indicated, was unat medication in the ca 483.25(I) DRUG RE UNNECESSARY D Each resident's dru unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer should be reduced combinations of the Based on a comprese	thium level checked since R75 had orders for lithium every three months and her aff need to carry the order out. .m. director of nursing blan and verified the care plan onate medication and ble to find lithium carbonate are plan. EGIMEN IS FREE FROM RUGS g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any	F	329			7/12/16

If continuation sheet Page 5 of 14

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 06/22/2016 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DAT	E SURVEY IPLETED
		24E116	B. WING			02/2016
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	
ANDREV	V RESIDENCE				215 SOUTH 9TH STREET IINNEAPOLIS, MN 55404	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	who have not used given these drugs u therapy is necessar as diagnosed and c record; and residen drugs receive gradu behavioral intervent	ge 5 antipsychotic drugs are not inless antipsychotic drug by to treat a specific condition locumented in the clinical ts who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these	F 3	29		
	by: Based on observat review, the facility fa monitoring was com failed to ensure the irregularities for 2 o reviewed for unnect Findings include: R91's undated Rec R91's diagnoses in schizoaffective disc characterized by at and deregulated en Review of R91's ph had an order for lat (HbA1c-a test that r sugar control over a done every three m	NT is not met as evidenced ion, interview and document ailed to ensure adequate ducted for irregularities, and physician was notified of f the 5 residents (R91, R75) cessary medications. ord of Admission indicated cluded, hypertension, order (a mental disorder mormal thought processes notions) and diabetes mellitus. ysician orders revealed R91 o test for Hemoglobin A1c measures an average blood a three month period) to be onths. edical record revealed R91 for HbA1c as follows;			<ul> <li>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</li> <li>How will corrective action be accomplished for resident identified as being affected?</li> <li>Both R 91 and R75 physicians respectively were contacted and where recommendations for subsequent follow up were made the follow-up has been conducted.</li> <li>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.</li> </ul>	

Facility ID: 00993

If continuation sheet Page 6 of 14

	<u> SFOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION		0938-039 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		IG		PLETED
		24E116	B. WING _		06/02/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ANDRE	V RESIDENCE			1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 329	<ul> <li>(normal 4.0 to 6.0 % glucose average of indicating lab result</li> <li>On 10/15/15, HbA</li> <li>% with an estimated 166. With a notation faxed to physician.</li> <li>On 1/7/16, HbA1c</li> <li>with an estimated a</li> <li>With a notation indit to physician.</li> <li>On 5/5/16, HbA1c</li> <li>with an estimated a</li> <li>With a notation indit to physician.</li> <li>On 5/5/16, HbA1c</li> <li>with an estimated a</li> <li>With a notation indit to physician.</li> <li>On 5/5/16, HbA1c</li> <li>with a notation indit to physician.</li> <li>Review of R91's me Nutritional Assessmant indicat</li> <li>was "considered recommendation to regarding elevated [primary medical do Metformin [medicat of diabetes] dose to [twice a day]."</li> <li>R91's medical recoon R91 had a schedule his primary physicia 5/16/16, which R91 record lacked evide physician to discuss and nutritional asses after R91 declined Review of the cons indicated R91's me</li> </ul>	Ige 6 I ab test with a result of 6.7 % %) with an estimated blood 146. With a notation is were faxed to physician. 1c lab test with a result of 7.4 d average blood glucose of in indicating lab results were alab test with a result of 7.9 % average blood glucose of 180. Icating lab results were faxed alab test with a result of 8.0 % average blood glucose of 183. Icating lab results were faxed edical record revealed a nent dated 4/8/16, the red R91's diabetes mellitus poorly controlled" and made o consult primary physician HbA1c lab results and "PMD botor] to consider increasing tion used in the management o 750mg [milligrams] BID rd was reviewed and revealed ed medical appointment with an on 3/24/16, 4/12/16, and declined to attend. The ence of contacting primary is elevated HgA1c lab results essment recommendations to attend the appointments. ultant pharmacist reports dication monitoring did not ies by the consultant	F 32	Measure put in place to ensure de practice will not recur Nursing staff will be provided with education by the Director of Nursii and/or designee on the protocol for monitoring labs, review nutrition assessments and follow-up communication with appropriate h care providers. This will be comple or before 07/12/2016. How will the plan be monitored to the solutions are sustained? Ongoing Monthly Audits for the ide issues will be conducted by the Di Nursing and/or designee. The find the audit will be reported to the Qu Assurance Committee each quart meeting.	ng ealth eted on ensure entified rector of ings of uality	

		AND HUMAN SERVICES			FORM	06/22/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		24E116	B. WING		06/	02/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ANDREW	<b>V RESIDENCE</b>			1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	Continued From pa pharmacist during t	ge 7 he monthly reviews.	F 329	)		
	with registered nurs acknowledged that his medical appoint 2016. RN-A and RN did not contact prim elevated HbA1c lab	tiew on 6/2/16, at 11:31 a.m. se (RN)-A and RN-B both R91 had declined to attend ment in March, April and May N-B both verified nursing staff nary physician to discuss o results and nutritional mendations after R91's appointment.				
	nursing (DON) state nursing staff to revie compare with previe communicate with t make an appointme clinic. DON verified attempt to commun	p.m. the facility's director of ed the expectation was ew the lab results and ous results and if abnormal the provider either by phone or ent for resident to be seen in that nursing staff did not licate with provider regarding o results after R91's missed				
	"LABORATORY RE 8/18/08, indicated la the facility's nurse a the lab report any a protocol further dire	ence's lab policy titled ESULTS PROTOCOL" dated ab results will be reviewed by and the nurse will document on action that was taken. The ected all abnormal results will prior results and the physician				
	awake and lying in interviewed regardin carbonate, R75 indi experience any side	on 6/2/16, at 9:19 a.m. to be bed. When approached and ng the medication, lithium icated he did not notice or e effects from the medication. to be relaxed with no				

If continuation sheet Page 8 of 14

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/22/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		24E116	B. WING			06/	02/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ANDREV	<b>V RESIDENCE</b>				215 SOUTH 9TH STREET /INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Continued From pa behaviors.	ge 8	F 3	829			
	8/11/04. R75's curred diagnoses which in schizophrenia, extra disorder, hypothyro generalized anxiety Furthermore, R75 h carbonate 300 milling morning and 600 m Schizophrenia. "Lith [three months]" on 7/16/15, 10/8/15 medical record lack level being drawn i an order to draw lith R75's quarterly Min indicated R75 had a antidepressant and the last seven days The MAR (Medicati January 2016, Febi 2016 and May 2016 lithium 300 mg by n addition, MARs idea carbonate 300 mg l mg by mouth at bea R75's care plan dat interventions to min movement. The inter medications per ph to treat Parkinson's extrapyramidal disc needed, monitor for	had an order for lithium grams (mg) by mouth in ig by mouth at bedtime for hium level Q [every] 3mo The lithium level was obtained , and 1/26/16, however, ted evidence of the lithium n April of 2016 and R75 had hium on 6/14/16. imum Data Set dated 4/21/16, an antipsychotic, antianxiety medications within within the last seven days. on Administration Record) for ruary 2016, March 2016, April 5, indicated R75 received nouth twice times a day. In htified, R75 received Lithium by mouth in morning and 600					

		AND HUMAN SERVICES				FORM	06/22/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		24E116	B. WING			06/0	02/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ANDREV	V RESIDENCE				215 SOUTH 9TH STREET /INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	and consult with MI needed. However, I documentation of m carbonate level bee On 6/2/16, at 11:04 verified R75's medi documentation of li 1/26/16, and stated level to be checked expectation was sta out. On 6/2/16, at 11:52 (DON) reviewed R7 confirmed the medi done since 1/26/16 lab level should hav was her expectation reconciliation from to anticipate the lab something missing, medical provider, si In addition, the DOI pharmacist would in regimen in her medi On 6/2/16 at 2:29 p (PC), stated, when medication, lithium resident labs are st provider ordered it, indicated, she did m levels because she lithium level every t The Andrew Reside MEDICATION REC	D as scheduled and as R75's medical record lacked nonitoring the lithium en obtain since 1/26/16. a.m. registered nurse (RN)-Z ical record lacked thium level checked since R75 had orders for lithium levery three months and her aff needed to carry the order a.m. director of nursing 75 medical record and ical record lacked lithium level , and stated another lithium ve been done in April 2016. It n that there would have been month to month and staff was o work and if there was , they should have notified the o the error could be corrected. N indicated "our consultant nclude this type medication dication regimen review."	F	329			

If continuation sheet Page 10 of 14

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 06/22/2016 APPROVED . 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DA	(X3) DATE SURVEY COMPLETED	
		24E116	B. WING		06	/02/2016	
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ANDREW	RESIDENCE				215 SOUTH 9TH STREET IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329 F 428 SS=D	and prepare a drug irregularities found. pharmacist to review findings, dietary cort to dosing and comb Neither the facility r lab level was not ob 483.60(c) DRUG RI IRREGULAR, ACT The drug regimen of reviewed at least or pharmacist. The pharmacist muthe attending physic	on regime on a monthly basis regime review summary with The policy indicated the w resident's laboratory nsiderations, concerns related bination of medications. for the CP noted R75's lithium stained per the MD's Order. EGIMEN REVIEW, REPORT		329 428		7/12/16	
	by: Based on interview facility failed to ensu- identified medicatio of the 5 residents (F unneccessary medi Findings include: R91's undated Reco R91's diagnoses ind schizoaffective diso characterized by ab				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		

Facility ID: 00993

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		1				0938-039
CIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION (X	,	SURVEY
	24E116	B. WING			06/0	2/2016
OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ENCE						
CH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIZ TAG	x			(X5) COMPLETIO DATE
ued From pa	age 11	F4	28			
order for la c-a test that control over very three m of R91's m o tests done 7/15, HbA10 a tests done 7/15, HbA10 a estimated of average of ng lab resul 0/15/15, HbA an estimated of average of ng lab resul 0/15/15, HbA10 estimated a notation ind sician. 5/16, HbA10 estimated a notation ind sician. 5/16, HbA10 estimated a notation ind sician. 0 f R91's m nal Assess ment indica considered nendation to ng elevated y medical do nin [medica etes] dose to a day]."	b test for Hemoglobin A1c measures an average blood a three month period) to be nonths. edical record revealed R91 for HbA1c as follows; c lab test with a result of 6.7 % %) with an estimated blood f 146. With a notation ts were faxed to physician. A1c lab test with a result of 7.4 ed average blood glucose of on indicating lab results were c lab test with a result of 7.9 % average blood glucose of 180. icating lab results were faxed c lab test with a result of 8.0 % average blood glucose of 183. icating lab results were faxed edical record revealed a nent dated 4/8/16, the ted R91's diabetes mellitus poorly controlled" and made o consult primary physician HbA1c lab results and "PMD octor] to consider increasing tion used in the management o 750mg [milligrams] BID			The Director of Nursing and/or design will complete audits of lab values for potentially affected residents. Any potentially identified issues will be corrected. This audit and any subseq follow-up will be completed by 07/12/2016. Measure put in place to ensure defici 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. Thi evaluation will include a systematic re of residents with lab orders and a rew of pharmacy consultation forms to en- identified issues are being addressed How will the plan be monitored to en- the solutions are sustained? The evaluation results will be forward the Quality Assurance committee by Director of Nursing or designee. The committee will assess completeness	all quent ient on is eview view nsure d. sure ded to the and	
	ued From pa v of R91's ph order for lai c-a test that control over every three m v of R91's m o tests done (7/15, HbA10 al 4.0 to 6.0 ° e average of ing lab resul 0/15/15, HbA10 an estimated ing lab resul 0/15/15, HbA10 notation ind sician. (7/16, HbA10 notation ind sician. (5/16, HbA10 notation ind sician. v of R91's m onal Assessr sment indica .considered mendation to ing elevated ing elevated ing elevated mendation to ing ing to set a day]."	A OR SUPPLIER ENCE SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) ued From page 11 v of R91's physician orders revealed R91 o order for lab test for Hemoglobin A1c c-a test that measures an average blood control over a three month period) to be every three months. v of R91's medical record revealed R91 o tests done for HbA1c as follows; /7/15, HbA1c lab test with a result of 6.7 % al 4.0 to 6.0 %) with an estimated blood e average of 146. With a notation ing lab results were faxed to physician. 0/15/15, HbA1c lab test with a result of 7.4 an estimated average blood glucose of /ith a notation indicating lab results were to physician. /7/16, HbA1c lab test with a result of 7.9 % n estimated average blood glucose of 180. notation indicating lab results were faxed sician. /5/16, HbA1c lab test with a result of 8.0 % n estimated average blood glucose of 183. notation indicating lab results were faxed sician. v of R91's medical record revealed a onal Assessment dated 4/8/16, the sment indicated R91's diabetes mellitus .considered poorly controlled" and made mendation to consult primary physician ing elevated HbA1c lab results and "PMD ry medical doctor] to consider increasing min [medication used in the management petes] dose to 750mg [milligrams] BID	24E116     B. WING       ROR SUPPLIER     ENCE       SUMMARY STATEMENT OF DEFICIENCIES GOLD SETICIENCY MUST BE PRECEDED BY FULL SULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFI TAG       ued From page 11     F.4       v of R91's physician orders revealed R91 order for lab test for Hemoglobin A1c c-a test that measures an average blood control over a three month period) to be every three months.     F.4       v of R91's medical record revealed R91 o tests done for HbA1c as follows;     F.7/15, HbA1c lab test with a result of 6.7 % al 4.0 to 6.0 %) with an estimated blood e average of 146. With a notation ing lab results were faxed to physician. 0/15/15, HbA1c lab test with a result of 7.4 an estimated average blood glucose of /ith a notation indicating lab results were to physician.     F.7/16, HbA1c lab test with a result of 7.9 % n estimated average blood glucose of 180. notation indicating lab results were faxed sician.       v of R91's medical record revealed a bician.     Mod R91's diabetes mellitus .considered poorly controlled" and made mendation indicating lab results and "PMD ry medical doctor] to consider increasing min [medication used in the management ietes] dose to 750mg [milligrams] BID a day]."	24E116     B. WING       R OR SUPPLIER     ID       ENCE     ID       SUMMARY STATEMENT OF DEFICIENCIES GACH DEFICIENCY MUST BE PRECEDED BY FULL BULATORY OR LSC IDENTIFYING INFORMATION)     PREFIX TAG       ued From page 11     F 428       v of R91's physician orders revealed R91 order for lab test for Hemoglobin A1c c-a test that measures an average blood control over a three month period) to be every three months.     F 428       v of R91's medical record revealed R91 o tests done for HbA1c as follows;     F 428       (7/15, HbA1c lab test with a result of 6.7 % al 4.0 to 6.0 %) with an otation ing lab results were faxed to physician.     F 428       (7/16, HbA1c lab test with a result of 7.4 an estimated average blood glucose of //ith a notation indicating lab results were to physician.     F 428       (7/16, HbA1c lab test with a result of 7.9 % n estimated average blood glucose of 180. notation indicating lab results were faxed sician.     F 428       v of R91's medical record revealed a onal Assessment dated 4/8/16, the sment indicated R91's diabetes mellitus .considered poorly controlled" and made mendation to consult primary physician ing elevated HbA1c lab results and "PMD ry medical doctor] to consider increasing min [medication used in the management ietes] dose to 750mg [milligrams] BID a day]."	24E116     B. WING       IOR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       ENCE     1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404       SUMMARY STATEMENT OF DEFICIENCIES with DEFICIENCY MUST BE PRECEDED BY FULL SULATORY OR LSC IDENTIFYING INFORMATION)     PREFIX TAG       Ured From page 11     F 428       v of R91's physician orders revealed R91 to order for lab test for Hemoglobin A1c c-a test that measures an average blood control over a three month period) to be wery three months.     F 428       v of R91's medical record revealed R91 to fests done for HbA1c tas follows; (7/15, HbA1c lab test with a result of 6.7 % al 4.0 to 6.0 %) with an estimated blood e average of 146. With a notation ing lab results were faxed to physician.     F 428       V/15/15, HbA1c lab test with a result of 7.4 an estimated average blood glucose of <i>lith</i> a notation indicating lab results were for physician.     F 428       v of R91's medical record revealed R91 to physician.     Norabition for HoA2 (as follows; (7/15, HbA1c lab test with a result of 7.4 an estimated average blood glucose of <i>lith</i> a notation indicating lab results were for anotation indicating lab results were faxed sician.     Norabition for a babes mellitus considered poorly controlled and made mendation to consult primary physician or estimated average blood glucose of 183. notation indicating lab results were faxed sician.     How will the plan be monitored to en the solutions are sustained? The evaluation results will be forwart the Quality Assurance committee by Director of Nursing or designee. The committee will assess completeness potential need for modifications in th process used by the consulting pharmacist.	24E116     B. WING     OC/O       SOR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     215 SOUTH 9TH STREET     MINNEAPOLIS, MN 55404       SUMMARY STATEMENT OF DEFICIENCIES SULATORY OR LSC IDENTIFYING INFORMATION)     ID     PREPX     ROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       ued From page 11     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.       v of R91's medical record revealed R91 o tests done for HbA1c as follows; 7/15, HbA1c lab test with a result of 7.9 an estimated average blood glucose of /ith a notation indicating lab results were o physician.     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 CA committee. This evaluation indicating lab results were faxed scian.       v of R91's medical record revealed a onal Assessment dated 4/8/16, the ment indicated R91's diabetes mellitus. considered poorly controled" and made mendation to consult primary physician ing elevated HbA1c lab test with a result of 8.0 % for harmacy consultation forms to ensure the solutions are sustained? The evaluation insults will be forwarded to the Quality Assurance committee by the Director of Nursing or designees. The committee will assess completeness and potential need for modifications in the process used by the consulting pharmacist.

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		AND HUMAN SERVICES			FORM	06/22/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		24E116	B. WING		06/	02/2016
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ANDREV	V RESIDENCE			215 SOUTH 9TH STREET /INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 428	his primary physicia 5/16/16, which R91 record lacked evide physician to discuss and nutritional asse after R91 declined to Review of the cons- indicated R91's me have any irregularit pharmacist during to During a joint interv- with registered nurs acknowledged that his medical appoint 2016. RN-A and RN did not contact prim elevated HbA1c lab assessment recom- missed May 2016 at On 6/2/16, at 12:48 nursing (DON) state staff to review the la previous results and with the provider eit appointment for res- verified that nursing communicate with p HbA1c lab results a appointments. During interview on facility's consulting does the monthly do residents in the faci drug reviews involv- results. CP stated r	an on 3/24/16, 4/12/16, and declined to attend. The ence of contacting primary s elevated HgA1c lab results essment recommendations to attend the appointments. ultant pharmacist reports dication monitoring did not ies by the consultant the monthly reviews. view on 6/2/16, at 11:31 a.m. se (RN)-A and RN-B both R91 had declined to attend tment in March, April and May N-B both verified nursing staff nary physician to discuss o results and nutritional mendations after R91's appointment. appointment. by phone or make an sident to be seen in clinic. DON g staff did not attempt to provider regarding elevated after R91's missed	F 428			

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		AND HUMAN SERVICES				FORM	06/22/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		24E116	B. WING			06/	02/2016
NAME OF	PROVIDER OR SUPPLIER	·			STREET ADDRESS, CITY, STATE, ZIP CODE		
ANDREV	ANDREW RESIDENCE				1215 SOUTH 9TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	monthly drug regim about the HbA1c la HbA1c lab results v have been commun acknowledged that increase in the HbA regimen reviews ar follow up with prima The Andrew Reside MEDICATION REG 3/27/00, directed th resident's medicatio and prepare a drug irregularities found. pharmacist to revie findings, dietary con	en reviews. When asked b results for R91, CP stated vere increasing and should nicated to the provider. CP she should have identified the A1c during the monthly drug ad made recommendations for	F	428			

Facility ID: 00993

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	MENT OF HEALTH			FEIL	6024	FORM	06/07/2016 APPROVED <u>0938-0391</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			PLE CONSTRUCTION 6 01 - MAIN BUILDING 01	(X3) DATE SUR COMPLET	
		24E116		B. WING		06/02	/2016
	ROVIDER OR SUPPLIER		1215 SC	RESS, CITY, S DUTH 9TH APOLIS, M			ě.
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI BE PRECEDED BY FULL NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS		K 000			
	Minnesota Departm Marshal Division on this survey, Andrew compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F (NFPA) Standard 10 Chapter 19 Existing Andrew Residence basement. The buil with an addition in 2 be of Type II(222) of	Survey was conduct nent of Public Safety of June 02, 2016. At t we requirements for pa id at 42 CFR, Subpa ety from Fire, and the Fire Protection Associ 01, Life Safety Code of Health Care. is a 5-story building ding was constructed 1978 and was determination construction. Each floo of 2 smoke zones by	, Fire he time of nd in articipation art e 2000 ciation e (LSC), g with a d in 1973, nined to por of the	*			
	automatic fire sprin accordance with NI Installation of Sprin The facility has a fir smoke detection ar on the fire alarm sy is monitored for aut notification. Hazard detection or smoke alarm system in ac State Fire Code. The facility has a ca census of 212 at th The facility was sur At this time, the cor	is protected with a c kler system installed PA 13 Standard for kler Systems (1999 re alarm system with d in common areas restem. The fire alarn tomatic fire departm lous areas have eith detection that are o cordance with the M apacity of 212 beds the time of the survey rveyed as one buildin nditions of 42 CFR,	I in the edition). a corridor that are n system ent er heat n the fire innesota and had a ng. Subpart		ж.		
LABORATO	RY DIRECTOR'S OR PROV	IDER/SUPPLIER REPRES	ENTATIVE'S SIG	NATURE	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.

DEPART CENTER	DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391								
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA /IBER:		PLE CONSTRUCTION 3 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED			
		24E116		B. WING		06/02/	2016		
ANDREW RESIDENCE 1215				RESS, CITY, S DUTH 9TH APOLIS, M					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE F BE PRECEDED BY FULL I ENTIFYING INFORMATION)	ES REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
K 000	Continued From pa 483.70(a) is MET.	age 1		K 000					
	14								
11			8						
					2				
				5					
						If continuation sh			

If continuation sheet Page 2 of 2