DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 31, 2021

Administrator
Andrew Residence
1215 South 9th Street
Minneapolis, MN 55404

RE: CCN: 24E116
Cycle Start Date: October 7, 2021

Dear Administrator:

On November 18, 2021, we notified you a remedy was imposed. On December 7, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 7, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 3, 2021 be discontinued as of December 7, 2021. (42 CFR 488.417 (b))

In our letter of November 4, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 2, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Electronically delivered

November 18, 2021

Administrator
Andrew Residence
1215 South 9th Street
Minneapolis, MN 55404

RE: CCN: 24E116
Cycle Start Date: October 7, 2021

Dear Administrator:

On November 4, 2021, we informed you that we may impose enforcement remedies.

On November 2, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On November 2, 2021, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. However, continued non-compliance remains at the lower scope and severity of G.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 3, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 3, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 3, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Andrew Residence is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective November 2, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 7, 2022 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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 _____	C 11/02/2021

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 On 10/28/21 to 11/2/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: HE116055C (MN77863) and HE116056C (MN77784) with a deficiency cited at F600. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. The survey resulted in an Immediate Jeopardy (IJ) at F600 when the facility failed to identify and implement interventions to protect residents from R2, when R2 admitted to the facility with a history of sexual assault. R2 sexually abused R1 and R3. The facility administrator, director of nursing (DON), and director of program services were notified of the IJ on 10/29/21, at 4:47 p.m. The IJ was removed on 11/2/21, at 11:37 a.m. but noncompliance remained at a lower scope and severity G, actual harm that is not immediate jeopardy.	F 000		

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

Electronically Signed | 11/22/2021

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.

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F 000	Continued From page 1 The above findings constituted substandard quality of care, and an extended survey was conducted from 11/1/21 to 11/2/21.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify and implement interventions for R2 upon admission who had a history of sexual assault to prevent sexual abuse for 2 of 2 residents (R1, R3) reviewed for abuse. R2 sexually abused R1 and R3. R1 experienced psychosocial harm as a result of the abuse. The IJ began on 9/20/21, when the facility failed to identify and implement interventions to protect residents when admitting R2 who had a history of sexual assault. R2 sexually abused R1 and R3. The facility administrator, director of nursing (DON), and director of program services were notified of the IJ on 10/29/21, at 4:47 p.m. The IJ	F 600	This Plan of Correction is prepared and executed because it is required by the provisions of the State and Federal regulations, and not because Andrew Residence agrees with the allegations and citations listed on this statement of deficiencies. Andrew Residence has appealed the alleged deficiency and licensing violation. This Plan of Correction shall operate as Andrew Residences written credible allegations of compliance. F600 Free from Abuse, Neglect, Exploitation	11/22/21

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F 600	Continued From page 2 was removed on 11/2/21, at 11:37 a.m. but noncompliance remained at a lower scope and severity G, actual harm that is not immediate jeopardy. Findings include: R2 R2's Pre-Admission Intake Form dated 8/26/21, indicated social services (SS)-C indicated a history of aggression which he was accused of grabbing/groping a person's breast. The intake indicated alleged 5th degree sexual conduct. R2's Criminal/Traffic/Petty Case Record Search Results dated 9/15/21, indicated R2 had been convicted of criminal sexual conduct- 5th degree-nonconsensual sex contact. R2's admission Minimum Data Set (MDS) dated 9/29/21, indicated intact cognition with minimal risk for depression. Daily R3 had behavior symptoms not directed toward others. R2 admitted on 9/20/21. R2 was independent in all areas of activities of daily living (ADL)'s. R2's admission Care Area Assessment (CAA) dated 9/29/21, indicated R2 had a history of criminal involvement which included burglary and assault (felony), burglary (misdemeanor) disorderly conduct (misdemeanor), criminal sexual conduct (gross misdemeanor) and theft (misdemeanor). R2 reported a "couple of assault charges" which were dropped including when he tried to stab his brother. R2 maintained poor boundaries and required redirection and reinforcement of boundaries. The facility Incident Report dated 10/18/21,	F 600	1.) The facility leadership team immediately reviewed the policies on admissions and vulnerability plans. 2.) All residents have the potential to be affected. No other residents were identified as affected upon audit. 3.) The Director of Program Services, together with the clinical staff responsible for vulnerability plan oversight have reviewed the policy for new resident vulnerability plan development. Persons responsible for vulnerability plan oversight have been educated on the policy and understand the expectation that a vulnerably plan be in place for any identified vulnerability that may put residents at risk for abuse or neglect. 4.) The policy as reviewed adequately addresses the need to have a vulnerability plan in place to prevent abuse. 5.) Training will be conducted for direct care staff members on abuse preventions as they are scheduled to work and for all staff on abuse reporting. 6.) The Director of Program Services or designee will monitor and will report to the QAPI committee during regular scheduled meetings and follow any recommendations as deemed necessary. 7.) Compliance will be achieved on 11/22/21.	

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F 600	Continued From page 3	F 600		

indicated R3 informed staff at 6:40 p.m. that R2 was "creeping her out." R3 explained that R2 kissed her earlier in the afternoon in her room and asked her to be his girlfriend. R3 described the kiss as non-consensual, R3 felt "not safe" with interactions with R2 and felt threaten by R2. R3 wanted to move rooms as R2 knew where she slept.

The facility Incident Report dated 10/18/21, indicated R2 was informed R3 felt uncomfortable with some of their interactions which seemed confusing to R2. R2's vulnerability assessment (plan of care) was updated 10/21/21, to include displayed sexually exploitive behavior so that additional care, support, and observation would be provided for R2.

The facility Brainboard Report dated 10/18/21, indicated R2 stated he may have come off too strong with his interaction with R3. R2 stated, "You've got to be careful these days" and referenced the Me-Too movement on how woman exaggerate charges to land men in jail.

The facility Brainboard Report dated 10/19/21, indicated R2 expressed statements of confusion about the incident with R3. R3 stated, "Why is this such a big deal if literally nothing happened?" R2 stated he sent R3 an apology text message earlier in the day but did not receive a response.

The facility Brainboard Report dated 10/20/21, indicated R2 was up at 2 a.m. and was not in his bed at 4 a.m. R2 was on and off the floor throughout the evening shift. R2 was observed looking at and greeted R3. In the evening, R2 stated he felt that the incident with R3 was unresolved and he was confused on what he had

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F 600	Continued From page 4	F 600		

done wrong.

The facility Incident Report dated 10/21/21, at 6:16 a.m. indicated R1 reported to the floor registered nurse (RN)-B that shortly after midnight she had been sexually assaulted twice. RN-B called PIC-A who discussed the incident with R1. R1 reported this man had twice grabbed her behind while walking past her as she stood in front of the announcements board on the way to the commons around 11:30 p.m. R1 then saw this man sit in a chair, "pretending" to be asleep and the man grabbed her behind again. Later, the man stood in the hallway by the menu, and appeared to be masturbating. R1 reported neither she nor the man spoke during any of these interactions, except when he appeared to be masturbating and R1 stated, "oh my god!" On the evening of the incident R1 reported that R2 may have been the person who assaulted her, but she was not positive. On 10/25/21, 10/26/21, 10/28/21, R2 admitted that he had touched R1. The police department was contacted to add the additional information that R2 was the man who assaulted R1.

R2's Plan of Care dated 10/21/21, indicated R2 displayed sexually exploitive behavior. Staff would provide education regarding personal boundaries and interpersonal skills; consider precaution checks as needed including one hour precaution check and location checks if there is concern of R2 engaged in immediate exploitative behaviors.

R2' progress note (PN) dated 10/21/21, at 6:50 a.m. indicated on 10/20/21, R1 was seen outside the building pacing back and forth and R2 entered the building around 11:15 p.m. At 11:20 p.m. R2 followed R1 and PIC-A into the dining

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F 600	Continued From page 5	F 600		

room with PIC-A but didn't appear to get anything. R2 stood and observed R1. R2 exited when he was asked to leave. At 11:45 p.m. a tablet was turned into staff that showed pornography sites and a dating application. At 12:30 a.m. R2 was asleep in his room and at 2:30 a.m. a door alarm was placed on stairway exit

R2's PN dated 10/21/21, at 11:53 a.m. indicated a conversation was held centered on two incidents. The first incident was on the facility tablet, which R2 left unattended in the commons area and was discovered to have pornography and potentially a dating/chat application open. R2 was asked about the involvement in an incident which occurred the evening 10/20/21, in with R1 was inappropriately touched by a male peer. R2 was the only resident identified by R1 as having potentially being involved. R1 stated, "I don't know" nor did R1 elaborate further when asked if he had any interactions with female peers which may have been misinterpreted.

R2's PN dated 10/21/21, at 2:44 p.m. R2 admitted and apologized for watching pornography on the facility tablet but denied this occurred in the commons. R2 was restricted from using facility tablets, restricted from all resident floors, restricted from the commons after 10:00 p.m., a door alarm was placed on his door, and placed on 1 hour location checks in addition to shift checks.

The facility Brainboard Report dated 10/24/21, indicated R2 exhibited agitation toward staff when paged to the desk after not being located on one of his location checks. The report indicated R2 was changed to two-hour location checks. Staff noticed R2 left his door partly ajar and were

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F 600	Continued From page 6	F 600		

unsure if this was intentional or an attempt to circumvent the doorbell.

The facility Brainboard Report dated 10/25/21, indicated R2 grazed the butt of the 3rd floor nurse twice while getting an assessment. A room search was conducted which a resident peer's underwear were found. R2 grabbed his penis in a sexual way and reached out and grazed the nurses butt for a third time. R2 presented with a labile mood and touched his genitalia two more times.

R2 PN dated 10/25/21, at 8:01 p.m. indicated staff searched R2's room and found woman's undergarment with initials from another female resident. R2 touched a staff member while she did an assessment. R2 admitted to sexually touching another resident and stated, "Can I be honest? I touched her." R2 explained the difficulty he was having with reintegration to society post 2-year jail term. R2 put his left hand into his shorts near his groin when staff engaged in discussion of their expectations. R2 removed his hand when R2 was asked to take his hands out of his pants. R2 stated he wanted to masturbate "all the time."

R2's Record of Admission indicated diagnoses of bipolar, depression, anxiety, post traumatic stress disorder. R2 was discharged on 10/26/21.

R3
R3's Diagnoses Report dated 9/21/21, indicated diagnoses of bipolar II disorder, borderline personality disorder, anxiety disorder.

R3's quarter MDS dated 10/15/21, indicated intact cognition. There was no presence of disorganized

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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thinking. R3 felt down, depressed, or hopeless half or more than half of the days. R3 was independent with ADL's.

The facility Brainboard Report dated 10/19/21, indicated R3 felt "weird" about the situation with R2. R3 endorsed feeling anxious. R3 asked if she could permanently move to the room behind the nurse's station. R3 expressed understanding when explained that she was only moved until a permanent solution was organized.
R3's progress note dated 10/27/21, at 9:25 p.m. indicated R3 was previously stressed about a negative experience with R2 but felt slightly better since he discharged.

R1
R1's Diagnoses Report dated 5/7/21, indicated anxiety, obsessive-compulsive disorder, borderline personality disorder, insomnia, and depression.

R1's quarterly MDS dated 8/21/21, indicated intact cognition. R1 was independent with ADL's. R1 has a minimal risk for depression.

R1's Plan of Care dated 10/21/21, indicated R1 was at risk for and/or had history of sexual victimization. R1 exhibited behaviors that allowed others to manipulate, exploit, victimize and bully. To reduce risk staff were to consider the following interventions: Encourage [R1] to report concerns related to relationships; Encourage R1 to report bullying and other manipulative behaviors; encourage to report any abuse to staff immediately; Staff would restrict visitors from R1's room and limit visits to common areas based on R1's preference; Engage R1 in discussion that define respectful relationships and develop

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	24E116	A. BUILDING _____ B. WING _____	C 11/02/2021

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assertiveness skills.

R1's PN dated 10/21/21, at 6:16 a.m. indicated shortly after midnight R1 reported that she had been sexually assaulted twice. R1 reported that a man had grabbed her behind twice. While walking past her as she stood in front of the announcement board on the way to the commons areas around 11:30 p.m. R1 saw him sitting in a chair "pretending" to be asleep but peeked at her from the corner of his eye. A little later R1 was in the commons getting change from the vending machine and the man grabbed her behind again. Later the man stood in the hallway by the menu and appeared to be masturbating. R1 reported that neither she nor the man spoke during any of these interactions, except when he appeared to be masturbating, R1 said "Oh my God!" When PIC-A and R1 entered the elevator later to try to identify the man there appeared to be ejaculate on the elevator floor. R1 looked at R2's photo and said that might be him. The security cameras were nonfunctional overnight. R1 reported she felt unsafe.

R1's PN dated 10/21/21, at 8:05 p.m. indicated R1 expressed feeling to be scared to leave the floor alone.

R1's PN dated 10/22/21, at 11:19 a.m. indicated R1 expressed hesitancy to spend time in the 1st floor common areas. R1 was informed that R2 was restricted from all residents' floors and the common areas after 10:00 p.m. R1 stated she just wanted to get back to the floor as soon as possible after the incident on 10/20/21.

R1's PN dated 10/22/21, at 11:18 p.m. indicated a resident peer accompanied R2 to get bagged

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dinner meal.

R1's PN dated 10/23/21, at 5:42 a.m. indicated a male friend from another floor expressed concern that R1 had not eaten all day long. This friend waited for R1 outside her room and accompanied her downstairs to obtain a bag meal around 12:30 a.m. R1 stated that she was fearful to go downstairs alone.

R1's PN dated 10/23/21, at 11:06 p.m. indicated R1 discussed the incident on 10/21/21, tearfully stated she should not experience that in her home and did not feel safe going around the building by herself.

R1's PN dated 10/26/21, at 3:55 p.m. indicated R1 was informed that R2 who was involved with the incident on 10/21/21, discharged. R1 replied, "I'm relieved. I don't have to feel scared to go downstairs anymore." R1 stated, "It doesn't mean I won't still have flash backs."

During an observation on 10/28/21, at 11:07 a.m. there were two female residents to the right, one female across and three females who resided left to R2's room prior to discharge.

During an observation on 10/28/21, at 1:06 p.m. R3's room was directly behind the nurse's station.

During an interview on 10/28/21, at 9:19 a.m. RN-A stated R1 was very anxious which caused issues interacting with others. RN-A stated R1 was an accurate reporter.

During an interview on 10/28/21, at 9:23 a.m. R1 stated the night of 10/20/21, she went downstairs to get a bag meal. R1 stated a guy came and

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squeezed her buttocks while she read information on the big bulletin board by the commons area. R1 looked to see who would have done that. R1 stated the guy did not say anything but looked at her and walked away. R1 further stated the guy continued to look and watch her after he squeezed her buttock then left toward the stairwell. R1 stated she sat down in the lobby and this guy came back from the stairwell and sat down in the same room as her. R1 stated she looked at him, but he pretended to be asleep and R1 knew he was awake since he peeked out of one eye and watched her. R1 stated she got up and went to the cash machine which he came up to her and squeezed her buttock again. R1 stated she just stood there for a moment while he went up the ramp. R1 thought R2 went back into the stairwell. R1 stated little did she know, he was standing at the top of the ramp just after he touched her butt for the second time and was masturbating. R1 stated she said, "Oh my God" after she saw R2 masturbating and was worried. R1 further stated she was scared and was not sure if he was going to try to do something else to her since she was alone with him. R1 stated she was not sure if R2 was "horny or what" for her. R1 stated after she said "oh my God" he stopped and went into the stairwell which she went into the elevator and straight to her room. R1 stated she called her sister to tell her what happened then informed the floor nurse. R1 stated she received help to identify who the man was whom they found out was R2. R1 stated after the incident she saw this man [R2] in the lobby which was uncomfortable. R1 further stated after the incident the night of 10/20/21, incident she had a friend go with her downstairs to help her feel safe. R1 was relieved and felt safer now that R2 had been discharged. R1 further stated since he was gone,

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she would now feel comfortable again to go downstairs. R1 stated even with him gone she had flashbacks and still thinks about the incident.

During an interview on 10/28/21, at 10:30 a.m. social services (SS)-B stated the facility was aware of R2's history of criminal sexual conduct where he tried to touch others and steal things. SS-B stated R2 was doing well upon admission, but things started to take a turn and there were two incidents where it was identified he was the individual who touched woman without their consent. SS-B stated there was an incident on 10/18/21, when R2 kissed R3 without R3's consent. SS-B stated after the incident on 10/18/21, R3 wanted to move to a new room to help her feel safe from R2. SS-B additionally stated R2 and R3 were educated to have no contact with another. SS-B stated R2 was placed on shift checks which consisted of staff to check in on R2 once a shift and document on his behavior. SS-B stated on 10/21/21, R1 initially was not able to identify whom touched her buttock but later believed it was R2 after she saw a picture of him. SS-B also stated the facility determined the man who touched her butt was R2 as through their investigation he was the only other male seen on the main floor at the time. SS-B stated after R2 touched R1 his shift checks were increased to hourly checks, an alarm was put on his door, Staff communicated to R2 that he was not allowed in the common areas after 10:00 p.m. and could only use the center stairwell. SS-B stated R2 continued to have a room near another woman after the incidents. SS-B stated there were 25 other females who resided on R2's floor.

During an interview on 10/28/21, at 2:59 p.m. RN-B stated on 10/20/21, just prior to the incident

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she saw R2 follow R1 into the dining room. RN-B stated R2 quickly turned to get water when he saw a staff member.

During an interview on 10/28/21, at 4:08 p.m. SS-B stated after the incident on 10/18/21, there were interventions put into place for R2's sexual behaviors which were added after the incident on 10/21/21. SS-B stated when residents admit to the facility with a history of behaviors the facility will have conversations with them to behave respectfully. SS-B stated prior to the incident on 10/18/21, there were no interventions in place for R2's sexual behaviors.

During an interview on 10/29/21, at 8:31 a.m. mental health worker (MHW)-A stated she arrived to work on 10/21/21, for the night shift and was informed that R1 had been assaulted twice. MHW-A stated R1 expressed concern about how this could happen to in her home. MHW-A stated after the incident on 10/21/21, R1 was scared to leave her room and go downstairs alone. MHW-A further stated when she arrived to work on 10/22/21, R5 came from a different floor asked MHW-A if he could escort R1 downstairs since R1 had not eaten all day. MHW-A stated R5 escorted R1 downstairs as it was confirmed R1 had not eaten and missed meals that day.

During an interview on 10/29/21, at 11:16 a.m. MHW-B stated she worked with R2 and was not aware of R2's sexual behaviors until an incident occurred on 10/18/21, with R3. MHW-B stated it was not surprising that R2 sexually assaulted the two women with his personality. MHW-B stated R2 was over confident and arrogant. MHW-B further stated R2 did what he wanted and did not care about others and could see R2 put his

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sexual desires over others.

During an interview on 10/29/21, at 11:50 a.m. SS-C stated R2's paperwork indicated he had an incident of a groping charge prior to his admission and criminal sexual history. SS-C stated R2 admitted to her that he was the one whom assaulted R1 and R3. SS-C also stated after R2 kissed R3 without her consent R2 tried to contact R3 via text.

During an interview on 10/29/21, at 12:21 p.m. R3 stated R2 creeped her out and wanted to be her boyfriend after she met him in the common area one time. R3 stated while they spoke R2 "all of a sudden" started to hug her. R3 stated when R2 hugged her he put her in a "bear hug" which made her very uncomfortable. R3 stated she was not able to get out of the bear hug and had to wait for him to let her go. R3 stated once R2 let her go she found an excuse and went to her room. R3 further stated R2 tried to come into her room, and she finally told staff after he came into her room and kissed her. R3 stated R2 would not have been in my room and tried to continue to go into her room after he kissed her. R3 stated after R2 kissed her the "weirdness continued" in the dining room where R2 rested his head on his hand and would stare at R3 from across the room. R3 stated she felt unsafe, weird, and annoyed after the incident as he continued to look at her. R3 stated she told staff as she was paranoid that he was always looking at her. R3 stated she was glad R2 was gone but she still thought about it, and it creeped her out.

During an interview on 10/29/21, at 1:14 p.m. the director of nursing (DON) verified R2's care plan had no indication of an intervention for his sexual

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F 600	Continued From page 14 behaviors until 10/21/21. During an interview on 10/29/21, at 2:30 p.m. MHW-C stated she was not aware of R2's history of sexual behaviors. MHW-C stated she would go to R2's care plan to know a resident's various vulnerabilities and interventions. The facility Vulnerable Adult Reporting Policy and Procedure dated 6/28/17, indicated sexual abuse was non-consensual sexual contact of any type with a resident. The immediate jeopardy that began on 9/20/21, was removed on 11/2/21, at 11:37 a.m. when the facility assessed all residents and identified no new residents to be at risk for sexual abuse. The residents whom had a history of sexual misconduct had vulnerably plan put into place that were current. The Director of Program Services with other clinical staff reviewed the policy for new resident vulnerably plan development. Staff whom were responsible for vulnerability plan oversight had been educated on the expectation that a vulnerability plan to be in place for any identified vulnerability that may put resdient at risk for abuse or neglect. The facility policy was reviewed which addressed the need to have a vulnerability plan in place. The facility trained all direct care staff on abuse prevention as they are scheduled work effective 11/1/21. Direct care staff would have focused vulnerability planning training. Interviews with staff and document review verified the steps were taken for the removal of the IJ.	F 600		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 18, 2021

Administrator
Andrew Residence
1215 South 9th Street
Minneapolis, MN 55404

Re: Event ID: RFQF11

Dear Administrator:

The above facility survey was completed on November 2, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/28/21 to 11/2/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: HE116055C (MN77863) HE116056C (MN77784); however, NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		