| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. Building<br>B. Wing | 11/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Andrew Residence | 1215 South 9th Street<br>Minneapolis, MN 55404 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and document review the facility failed to ensure 4 of 4 residents (R1, R2, R3, R4) reviewed for abuse were free of sexual abuse when R1, R3 and R4 were subjected to unwanted sexual touch by R2.Findings include: R1's annual Minimum Data Set (MDS) dated [DATE], indicated R1 had intact cognition and diagnoses that included bipolar disorder, (a mental health condition characterized by extreme shifts in mood, energy and activity levels), anxiety, post-traumatic stress disorder, and depression, and borderline personality disorder (a mental health condition characterized by long-term patterns of unstable emotions, relationships, and self-image, leading to impulsive and self-destructive behavior). R1's care plan dated 10/3/24 indicated R1 was at risk for and/or had a history of sexual victimization and dated 5/27/25 indicated R1 exhibited behaviors that allowed others to manipulate, exploit, victimize, and bully her. R1's Interpersonal Skills Assessment (IPS) assessment dated [DATE], indicated a history of sexual trauma and victimization related to being sexually trafficked. R1's progress notes dated 11/13/25 at 1:35 p.m., entered as a late entry for 11/7/25 at 1:30 p.m., revealed R1's family member called the facility, spoke to SW-A, and reported someone had gone in R1's room and made sexual advances towards R1. R2's annual MDS dated [DATE] indicated intact cognition and diagnoses that included paranoid schizophrenia (a chronic mental disorder that affects how a person thinks, feels, and behaves, causing a break from reality that may include symptoms of paranoia, false beliefs, seeing or hearing things that are not there, disorganized thinking and speech, and lack of normal emotional expression). R2's care plan dated 11/13/25, indicated R2 displayed sexually exploitive behavior with interventions that included restriction from visiting all other residential floors, and consider precaution checks as needed. On 11/17/25, the care plan was adjusted to restrict R2 from other residential floors, female rooms, and the short hall of R2's residential floor and for staff to remind R2 weekly and as needed of behavioral expectations related to not exposing himself or asking other residents to engage in any sexual activity. The care plan lacked interventions to protect other residents from unwanted advances after being informed of the behavior on 11/7/25. R2's IPS assessment dated [DATE] indicated when R2 was symptomatic misperceived communication from others resulting in interpersonal conflict. R2 had a history of participating in unwanted physical contact and violating no-contact orders. R2 understood others must have the capacity to consent to sexual activity before and throughout the activity and demonstrated knowledge of consent. The Assessment indicated no care plan in place for sexual exploitation or other vulnerability related to sexual health at the time of assessment. The assessment lacked indication of a care plan to address behaviors when symptomatic, despite a history of unwanted physical contact and violations of no-contact orders. Further, the assessment lacked indication of an update after R2's behaviors changed. R2's progress notes indicated the following:-11/12/25 at 10:58 p.m., indicated a resident [R4] reported unwanted advancements from R2. Staff spoke to R2, who stated he was getting mixed signals from the other resident but agreed to respect others' boundaries. Staff restricted R2 from visiting R4's floor. -11/13/25 at 3:15 p.m., indicated R2 was placed on 1-hour location checks and shift checks due to multiple incidents of<br>(continued on next page) |

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.

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 24E116 | A. Building<br>B. Wing | 11/25/2025 |

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| Andrew Residence | 1215 South 9th Street<br>Minneapolis, MN 55404 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | inappropriate interaction with numerous residents.-11/17/25 at 11:00 p.m., indicated staff met with R2 after R2 exposed himself to another resident [R3]. R2 was prohibited from entering other residential floors, female rooms, and the other hall of his own floor. Staff included police in the discussion with R2. -11/18/25 at 6:44 a.m., indicated R2 remained on 1-hour location checks and shift checks due to multiple incidents on 11/12/25, 11/13/25, and 11/17/25 and post SA reports on 11/13/25 and 11/17/25 related to R2's poor sexual boundaries. -11/19/25 at 10:49 p.m., indicated interventions were added to R2's care plan - R2 was restricted from visiting other residential floors, female rooms, and the short hall of his own residential floor. During an observation on 11/20/25 at 11:54 a.m., R1 was in his room asleep. Staff awakened R2 while performing a schedule check on him. R3's annual MDS dated [DATE] indicated intact cognition and diagnoses that included anxiety, borderline personality disorder, and depression. R3's care plan dated 1/23/17 indicated a risk and/or history of sexual victimization with an update on 11/17/25 to notify staff of distressing interactions, use her pull cord to get help from staff as needed, and to discuss safety planning weekly and as needed. R3's IPS assessment dated [DATE], indicated R3 struggled to set appropriate boundaries and had a history of sexual abuse.R3's progress notes dated 11/17/25, indicated R3 reported R2 walked across her room naked to close the door when he was visiting R3's roommate, and then later, she was left alone with R2, and R2 engaged in inappropriate sexual conversation with R3 and exposed himself, which made R3 very uncomfortable. The subsequent SA 5-Day report dated 11/18/25 at 2:18 p.m., indicated R2 exposed himself to R3, R2 had sexual relations with R2's roommate, and boundary concerns were expressed about R2 on 11/12/25 involving R2 kissing R4. The report also revealed a separate incident in which R2 exposed himself days earlier but was not reported at the time. During staff follow-up discussions with R2, R2 displayed limited insight into the impact and distress caused by exposing himself to another resident and acknowledged exposing himself after R1 explicitly told him she did not want to engage in sexual relations with him. R4's quarterly MDS dated [DATE] indicated moderate cognitive impairment and diagnoses that included depression, anxiety, and schizoaffective disorder (a chronic mental health condition that combines symptoms of schizophrenia-a thought disorder such as delusions and hallucinations with symptoms of a mood disorder like bipolar disorder or depression). R4's care plan dated 6/11/25, indicated risk and/or history of sexual victimization. On 8/15/25, the care plan indicated staff would monitor for interactions in common spaces between R4 and R2 and intervene to assist R4 in setting boundaries, and on 11/12/25, the care plan was updated with an intervention to restrict R2 from R4's residential floor. R4's IPS assessment dated [DATE], indicated a history of physical and sexual abuse and R4 as a victim of sexual exploitation. R4's progress notes indicated the following: -11/12/25 at 10:37 p.m., indicated R2 embraced R4 in R4's room doorway and staff intervened due to R2's history of poor boundaries. R4 reported R2 kissed R4 on the cheek and it was unwanted, and the same behavior occurred a few times in the previous week. Staff discussed boundary-setting with R4, and R4 acknowledged difficulty setting boundaries. -11/13/25 at 6:53 a.m., indicated R4 was on shift checks due to an uncomfortable interaction with her peer. -11/13/25 at 2:40 p.m., indicated R4 requested a meeting with staff and indicated she was unable to maintain boundaries with R2 and asked for staff assistance to maintain distance from R2. An intervention was added to R2's care plan to restrict R2 from R4's residential floor. During an interview on 11/19/25 at 2:50 p.m., R4 stated R2 tried to kiss her on two different occasions. The first was when R2 asked R4 to come to his room to show R4 his TV but then R2 wouldn't stop touching or kissing R4. After that incident, R2 was banned from R4's residential floor. R4 stated the second incident was when R2 kissed her in the hallway outside her room, R4 said no, R2 kissed her again, and staff intervened. R4 stated R2 was supposed to be banned from her floor but was there anyway. During an interview on 11/20/25 at 11:59 a.m., R2 stated he kissed R4 on the cheek, R4 said no and R2 kissed R4 again. R2 stated he was already restricted from being on R4's residential floor from a different incident, but had forgotten about the restriction and went there anyway. R2 stated he was not allowed to have sexual relations with women in the facility, (continued on next page) |

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|---|---|---|---|
| | 24E116 | A. Building<br>B. Wing | 11/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Andrew Residence | 1215 South 9th Street<br>Minneapolis, MN 55404 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | and stated, They [staff] are acting like it was all my fault, like I am a hungry, thirsty, sex fiend just looking to f**k. They [the other residents he had approached for sex] wanted to be friends and invited me over. During an interview on 11/20/25 at 10:59 a.m., FM-A stated on 11/7/25, R1 reported a male resident came into her room and made sexual advances towards her, would back off, and then would try again. R1 did not want FM-A to report the incident to the facility but FM-A called the facility on 11/7/25 and reported the incident to the SW-A so it would not happen to anyone else. During an interview on 11/20/25 at 1:03 p.m., SW-A stated she became aware of an incident between R1 and R2 after FM-A called on 11/7/25, and reported unwanted touch by R2 to R1. SW-A stated she attempted to reach the R1 for more information but was unsuccessful, did inform other staff on shift and told the Program Director (PD)-A in passing but had not documented any of that information. SW-A confirmed no investigation or protections were started or considered until she returned to work on 11/12/25. During an interview on 11/21/25 at 11:01 a.m., R1 stated she reported the incident to her parents because authority figures at the facility freak me out. [R2] went further than he should have. R1 informed her parents she was harassed, and had to yell at R2 and threaten to pull the alert cord to get staff's help because R2 would not leave her room. R1 stated she went to R2's room to look at something he wanted to sell and then left his room and went back to her own room. About 5 minutes later, R2 came to R1's room with a scarf he thought R1would like, and R1 stated she wanted the scarf. R1 showed R2 old pictures from her high school yearbook, and thought maybe R2 liked her because she showed him pretty pictures of herself. R1 stated she allowed R2 to lay on her bed with her but stated she did not want anything sexual to happen, did not want to kiss, and kept saying no. R1 told R2 she never wanted to have sex with him and R2 was shocked and asked, Never? R1 said no, she was gay and was not interested in any man. R1 told R2 she didn't like any penis, and R2 kept saying R1 might like to see it, and then R2 exposed himself and told R1 she had never tried sex with him, and she might like it. R2 reached across R1, who was lying on her bed and, He used that opportunity to kind of grind on me. R1 yelled at R2 and threatened to use the pull cord to summon staff, and R2 left the room. R1 stated she had a long, extensive history of sexual trauma. During an interview on 11/20/25 at 11:59 a.m., R2 stated he had been asleep in his room all morning while wearing headphones and had not left his room. R2 stated R1 invited him to lay on her bed with her, showed him her stomach, and allowed R2 to touch it. R2 asked if R1 had ever been with a boyfriend, and R1 stated she had but it never ended well. R2 stated he didn't know what to do because he was confused after R1 let R2 touch her stomach, so he pulled his pants down, and reached across both R1 and the bed to look for something. R2 stated R1 told him to leave or R1 was going to pull the call light to get staff assistance. R2 stated he took that seriously and left the room. During an interview on 11/19/25 at 4:55 p.m., R3 stated R2 exposed himself to her twice, but could not recall the dates. R3 stated she was in the room when R2 and her roommate, were together, R2 walked across the room with his penis exposed, and didn't say anything to R3 at the time. The second incident was after R2, and her roommate had sex with her in the room. Afterwards her roommate left the room, and R2 exposed himself to her. R3 stated she was uncomfortable with the incident, she didn't want to see R2's penis, was afraid of R2 and that he, Would try something with me. R3 stated R2 asked her personal questions, asked if she wanted to touch it or suck it (penis), and she told R2 she did not want to. R3 then stated R2 put his penis away, but stayed in the room, sat on her bed, and continued to make her feel uncomfortable so she thought R2 still wanted something from her. During an interview on 1120/25 at 11:59 a.m., R2 stated he had been having a sexual encounters with R3's roommate, and afterwards she left the room he was alone with R3. R2 asked to sit on R3's bed, asked R3 if she ever had sex with someone and if she thought about having sex, and offered to show R3 his penis. He indicated she said no, but he still thought maybe she wanted to see it, so he took his penis partially out of his pants and R3 looked. R2 then asked her if she wanted to see the rest of it, and since R3 didn't say no, he took his penis fully out of his pants. R2 stated it was his duty to ask if R3 was uncomfortable but hadn't and thought R3 looked confused and uncomfortable. R2 put his penis (continued on next page) |

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| | 24E116 | A. Building<br>B. Wing | 11/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Andrew Residence | 1215 South 9th Street<br>Minneapolis, MN 55404 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | back in his pants and left the room. During an interview on 11/20/25 at 1:34 p.m., the PD-A stated she became aware of the incident on 11/13/25, when SW-A informed her about the report from FM-A received on 11/7/25. The PD-A acknowledged no one followed up, the incident was not relayed to other staff, the incident should have been investigated sooner. The PD-A stated she was not sure a full-on investigation was needed, but the facility needed more details, and if the follow-up had occurred on 11/7/25, interventions could have been implemented to protect R1 and other residents. PD-A stated after the facility had more information the State report was filed on 11/13/25. PD-A acknowledged she didn't think any staff had investigated or asked R1 what happened or who was involved from 11/7/25 to 11/13/25. The Vulnerability Adult Reporting Policy and Procedure dated 9/28/22, indicated when there are occurrences of resident - to - resident abuse, the facility shall take immediate action to protect the resident(s) involved. The policy stipulates abuse included sexual abuse, and is willful, meaning the individual acted deliberately, and is any non-consensual contact of any type with a resident. Any facility associate who has knowledge of the maltreatment of a resident, or has a reasonable cause to believe that a resident has been maltreated, shall immediately make a verbal report to the supervisor or person in charge and complete an incident report. The person in charge shall inform the administrator. Allegations of abuse shall be reported immediately, but not later than 2 hours after the allegation is made or after forming the suspicion to the State Agency. Reporting is a two-step process, initially reporting and then submitting an investigative report, within 5 working days of the incident.After an internal report of maltreatment is made, the Director of Clinical Services shall investigate the incident. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to report an allegation of alleged sexual abuse immediately (within two hours) to the State Agency (SA) for 3 of 4 residents (R1, R2) when R2 was alleged to make unwanted sexual advances towards R1 and R4. Findings include: R1's annual Minimum Data Set (MDS) dated [DATE], indicated R1 had intact cognition and diagnoses that included bipolar disorder, (a mental health condition characterized by extreme shifts in mood, energy and activity levels), anxiety, post-traumatic stress disorder, and depression, and borderline personality disorder (a mental health condition characterized by long-term patterns of unstable emotions, relationships, and self-image, leading to impulsive and self-destructive behavior). The State Agency report dated 11/13/25, indicated R1's family member (FM)-A reported on 11/7/25 an incident of romantic overtures by R2 in R1's room to social worker (SW)-A. R2 exposed himself to R1 and R2 and pushed his pelvis against R1's hip. Per the SA report, the facility began the investigation on 11/12/25, and no report for alleged abuse was filed for R1 until 11/13/25. R1's care plan dated 10/3/24 indicated R1 was at risk for and/or had a history of sexual victimization and also indicated R1 exhibited behaviors that allowed others to manipulate, exploit, victimize, and bully her, dated 5/27/25.R1's Interpersonal Skills Assessment (IPS) assessment dated [DATE], indicated diagnoses that included post-traumatic stress disorder and further indicated a history of sexual trauma and victimization related to being sexually trafficked. R1's progress notes dated 11/13/25 at 1:35 p.m., entered as a late entry for 11/7/25 at 1:30 p.m., indicated R1's family member called the facility, spoke to SW-A, and reported another resident went into R1's room and made sexual advances towards R1. During an interview on 11/20/25 at 10:59 a.m., FM-A stated on 11/7/25 R1 reported a male resident came into her room and made sexual advances towards her, would back off, and then would try again. R1 did not want FM-A to report the incident to the facility but FM-A called the facility on 11/7/25 and reported the incident to SW-A so it would not happen to anyone else. During an interview on 11/20/25 at 1:03 p.m., SW-A stated she became aware of an incident between R1 and R2 after FM-A called on 11/7/25 and reported unwanted touch by R2 to R1. SW-A stated she attempted to call R1 several times after the report to inquire about the details of the incident but was unable to reach her as she was already on leave from the facility. SW-A stated she reported the incident to an evening staff, but didn't recall who, and acknowledged she had not documented the report from FM-A, the report to the evening staff, or the attempted phone calls to R1. SW-A further stated she did not tell administrative staff about FM-A's report because without talking to R1 first about the details of the incident, there was not enough information at the time to make a report to the State. SW-A stated she told the program director (PD)-A about the incident in passing on her way out of the building, after her shift but had not documented that either. SW-A acknowledged if a resident reported unwanted touch by another resident, the event would be reportable within two hours of the incident or within two hours of staff knowing about the incident but thought she would need to obtain full details of the incident before making the report. SW-A was then off work for four days and started to follow up on the report when she returned to work on 11/12/25. During an interview on 11/20/25 at 1:34 p.m., the PD-A stated she became aware of the incident between R1 and R2 on 11/13/25, when SW-A informed her about the phone call from FM-A on 11/7/25. SW-A tried to reach R1 on 11/7/25, and the primary focus and direction around the event was R1 had asked the person to leave, and they did, but the facility needed to know more about the unwanted touch before it was reportable. The PD-A stated the expectation was for SW-A to get clarification with R1's treatment team about who would follow up. The PD-A stated no one followed up, and it was not relayed to other staff, but acknowledged it should have been investigated sooner. The PD-A stated she was not sure a full-on investigation was needed, but the facility needed more details, and if the follow-up had occurred on 11/7/25, interventions could<br>(continued on next page) |

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| | 24E116 | A. Building<br>B. Wing | 11/25/2025 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | have been implemented to protect R1 and other residents. PD-A stated after the facility had more information the State report was filed on 11/13/25. PD-A acknowledged she didn't think any staff had investigated or asked R1 what happened or who was involved from 11/7/25 to 11/13/25. During an interview on 11/21/25 at 9:11 a.m., program manager (PM)-A stated she was informed of the incident between R1 and R2 from SW-B but was unsure of the date. The PM-A stated if someone made sexual advances towards a resident, staff should interview the resident, inquire if they needed additional support, perform an investigation, and make a State Agency report of abuse. During an interview on 11/21/25 at 9:39 a.m., SW-B stated staff informed her of the incident between R1 and R2 on 11/14/25 and was told a resident forced himself into R1's room and tried to force himself on her. SW-B stated staff should have interviewed R1 on 11/7/25 when they knew of the incident. SW-B stated it sounded like a traumatizing experience, but especially so with a sexual trauma history and unwanted sexual contact would be difficult for any resident. During an interview on 11/21/25 at 11:01 a.m., R1 stated she reported the incident to her parents because authority figures at the facility freak me out. [R2] went further than he should have. R1 informed her parents she was harassed and had to yell at R2 and threaten to pull the alert cord to get staff's help because R2 would not leave her room. R4's quarterly MDS dated [DATE] indicated moderate cognitive impairment and diagnoses that included depression, anxiety, and schizoaffective disorder (a chronic mental health condition that combines symptoms of schizophrenia-a thought disorder such as delusions and hallucinations with symptoms of a mood disorder like bipolar disorder or depression). R4's care plan dated 6/11/25, indicated risk and/or history of sexual victimization. On 8/15/25, the care plan indicated staff would monitor for interactions in common spaces between R4 and R2 and intervene to assist R4 in setting boundaries, and on 11/12/25, the care plan was updated with an intervention to restrict R2 from R4's residential floor. R4's IPS assessment dated [DATE], indicated a history of physical and sexual abuse and R4 as a victim of sexual exploitation. R4's progress notes indicated the following:-11/12/25 at 10:37 p.m., indicated R2 embraced R4 in R4's room doorway and staff intervened due to R2's history of poor boundaries. R4 reported R2 kissed R4 on the cheek and it was unwanted, and the same behavior occurred a few times in the previous week. Staff discussed boundary-setting with R4, and R4 acknowledged difficulty setting boundaries.-11/13/25 at 6:53 a.m., indicated R4 was on shift checks due to an uncomfortable interaction with her peer.-11/13/25 at 2:40 p.m., indicated R4 requested a meeting with staff and indicated she was unable to maintain boundaries with R2 and asked for staff assistance to maintain distance from R2. An intervention was added to R2's care plan to restrict R2 from R4's residential floor. During an interview on 11/19/25 at 2:50 p.m., R4 stated R2 tried to kiss her on two different occasions. The first was when R2 asked R4 to come to his room to show R4 his TV but then R2 wouldn't stop touching or kissing R4. After that incident, R2 was banned from R4's residential floor. R4 stated the second incident was when R2 kissed her in the hallway outside her room, R4 said no, R2 kissed her again, and staff intervened. R4 stated R2 was supposed to be banned from her floor but was there anyway. During an interview on 11/20/25 at 11:59 a.m., R2 stated he kissed R4 on the cheek, R4 said no and R2 kissed R4 again. R2 stated he was already restricted from being on R4's residential floor from a different incident, but had forgotten about the restriction and went there anyway. R2 stated he was not allowed to have sexual relations with women in the facility, and stated, They [staff] are acting like it was all my fault, like I am a hungry, thirsty, sex fiend just looking to f**k. They [the other residents he had approached for sex] wanted to be friends and invited me over. During an interview on 11/20/25 at 3:57 p.m., the director of clinical services (DCS)-A stated R1 was not always a strong self-advocate. R1 talked to the program manager about the incident on the 11/12/25, but didn't fully disclose the details until 11/13/25, when the incident was reported. The DCS-A stated the facility staff should have asked R1 about the incident sooner if the SW knew about the incident on 11/7/25. The DCS-A further stated the facility didn't report the incident to the SA until 11/13/25 because the facility didn't have the full details to report. The DCS-A stated the facility did not have to ask R1 about the details again after R1 declined to give the details<br>(continued on next page) |

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|---|---|---|---|
| | 24E116 | A. Building<br>B. Wing | 11/25/2025 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | on 11/12/25, but the facility did ask again, which was good on their part. The DCS-A stated potentially R1 could have disclosed the details sooner if she had been asked about it sooner. Additionally, when asked about the abuse staff observed between R2 and R4, DCS-A stated, [R4] and [R2] just kissed and staff intervened immediately. That was not reportable. The Vulnerability Adult Reporting Policy and Procedure dated 9/28/22, indicated when there are occurrences of resident - to - resident abuse, the facility shall take immediate action to protect the resident(s) involved. The policy stipulates abuse included sexual abuse, and is willful, meaning the individual acted deliberately, and is any non-consensual contact of any type with a resident. Any facility associates who has knowledge of the maltreatment of a resident or has a reasonable cause to believe that a resident has been maltreated shall immediately make a verbal report to the supervisor or person in charge and complete an incident report. The person in charge shall inform the administrator. Allegations of abuse shall be reported immediately, but not later than 2 hours after the allegation is made or after forming the suspicion to the State Agency. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24E116 | A. Building<br>B. Wing | 11/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Andrew Residence | 1215 South 9th Street<br>Minneapolis, MN 55404 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to immediately respond, investigate timely, and implement resident protections for 4 of 4 residents (R1, R2, R3, R4) after an allegation of sexual abuse of R1 by R2 was reported, which resulted in subsequent sexual abuse for R3 and R4. The immediate jeopardy began on 11/7/25 at 1:30 p.m., when R1's family member (FM)-A reported unwanted sexual touching, by R2 to R1 while the residents were in R1's room, to the Social Worker (SW)-A and the facility failed to timely report the incident to the State Agency, begin an investigation, and place resident protections to ensure other vulnerable residents at risk of sexual abuse were safe. The director of clinical services (DCS)-A and director of nursing (DON) were notified of the immediate jeopardy at 5:02 p.m. on 11/20/25. The immediate jeopardy was removed on 11/21/25, but noncompliance remained at the lower scope and severity level D - isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include:R1's annual Minimum Data Set (MDS) dated [DATE], indicated R1 had intact cognition and diagnoses that included bipolar disorder, (a mental health condition characterized by extreme shifts in mood, energy and activity levels), anxiety, post-traumatic stress disorder and depression, and borderline personality disorder (a mental health condition characterized by long-term patterns of unstable emotions, relationships, and self-image, leading to impulsive and self-destructive behavior.)R1's care plan dated 10/3/24 indicated R1 was at risk for and/or had a history of sexual victimization and dated 5/27/25 indicated R1 exhibited behaviors that allowed others to manipulate, exploit, victimize, and bully her. R1's Interpersonal Skills Assessment (IPS) assessment dated [DATE], indicated a history of sexual trauma and victimization related to being sexually trafficked. R1's progress notes dated 11/13/25 at 1:35 p.m., entered as a late entry for 11/7/25 at 1:30 p.m., revealed R1's family member called the facility, spoke to SW-A, and reported someone had gone in R1's room and made sexual advances towards R1.R2 R2's annual MDS dated [DATE] indicated intact cognition and diagnoses that included paranoid schizophrenia (a chronic mental disorder that affects how a person thinks, feels, and behaves, causing a break from reality that may include symptoms of paranoia, false beliefs, seeing or hearing things that are not there, disorganized thinking and speech, and lack of normal emotional expression.) R2's care plan dated 11/13/25, indicated R2 displayed sexually exploitive behavior with interventions that included restriction from visiting all other residential floors, and consider precaution checks as needed. On 11/17/25, the care plan was adjusted to restrict R2 from other residential floors, female rooms, and the short hall of R2's residential floor and for staff to remind R2 weekly and as needed of behavioral expectations related to not exposing himself or asking other residents to engage in any sexual activity.R2's IPS assessment dated [DATE] indicated when R2 was symptomatic, misperceived communication from others resulting in interpersonal conflict. R2 had a history of participating in unwanted physical contact and violating no-contact orders. R2 understood others must have the capacity to consent to sexual activity before and throughout the activity and demonstrated knowledge of consent. The Assessment indicated no care plan in place for sexual exploitation or other vulnerability related to sexual health at the time of assessment. The assessment lacked indication of a care plan to address behaviors when symptomatic, despite a history of unwanted physical contact and violations of no-contact orders.R2's progress notes indicated the following:-11/12/25 at 10:58 p.m., indicated a resident [R4] reported unwanted advancements from R2. Staff spoke to R2, who stated he was getting mixed signals from the other resident but agreed to respect others' boundaries. Staff restricted R2 from visiting R4's floor (3rd).-11/13/25 at 6:56 a.m., R2 was noted to be on the 3rd floor, found in R4's room having consensual sex with her roommate. Progress note did not indicate any immediate action or supervision to ensure R2's stayed off 3rd floor.-11/13/25 at 3:15 p.m., indicated R2 was placed on 1-hour location checks and shift checks due to multiple incidents of inappropriate interaction with<br>(continued on next page) |

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| | 24E116 | A. Building<br>B. Wing | 11/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Andrew Residence | 1215 South 9th Street<br>Minneapolis, MN 55404 |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | numerous residents.-11/17/25 at 11:00 p.m., indicated staff met with R2 after R2 exposed himself to another resident (R3). R2 was prohibited from entering other residential floors, female rooms, and the other hall of his own floor. Staff included police in the discussion with R2.-11/18/25 at 6:44 a.m., indicated R2 remained on 1-hour location checks and shift checks due to multiple incidents on 11/12/25, 11/13/25, and 11/17/25 and post SA reports on 11/13/25 and 11/17/25 related to R2's poor sexual boundaries.-11/19/25 at 10:49 p.m., indicated interventions were added to R2's care plan - R2 was restricted from visiting other residential floors, female rooms, and the short hall of his own residential floor.During an interview on 11/20/25 at 10:59 a.m., FM-A stated on 11/7/25, R1 reported a male resident came into her room and made sexual advances towards her, would back off, and then would try again. R1 did not want FM-A to report the incident to the facility but FM-A called the facility on 11/7/25 and reported the incident to the SW-A so it would not happen to anyone else. During an interview on 11/20/25 at 1:03 p.m., SW-A stated she became aware of an incident between R1, and R2 after FM-A called on 11/7/25, and reported unwanted touch by R2 to R1. SW-A stated she attempted to call R1 several times after the report to inquire about the details of the incident but was unable to reach her as she was already on leave from the facility. SW-A stated she reported the incident to an evening staff, but didn't recall who, and acknowledged she had not documented the report from FM-A, the report to the evening staff, or the attempted phone calls to R1. SW-A further stated she did not tell administrative staff about FM-A's report because without talking to R1 first about the details of the incident, there was not enough information at the time to make a report to the State. SW-A stated she told the program director (PD)-A about the incident in passing on her way out of the building, after her shift but had not documented that either. SW-A acknowledged if a resident reported unwanted touch by another resident, the event would be reportable within two hours of the incident or within two hours of staff knowing about the incident, but thought she would need to obtain full details of the incident before making the report. SW-A was then off work for four days and started to follow up on the report when she returned to work on 11/12/25.During an interview on 11/21/25 at 11:01 a.m., R1 stated she reported the incident to her parents because authority figures at the facility freak me out. [R2] went further than he should have. R1 informed her parents she was harassed, and had to yell at R2 and threaten to pull the alert cord to get staff's help because R2 would not leave her room. R1 stated she went to R2's room to look at something he wanted to sell and then left his room and went back to her own room. About 5 minutes later, R2 came to R1's room with a scarf he thought R1 would like, and R1 stated she wanted the scarf. R1 showed R2 old pictures from her high school yearbook, and thought maybe R2 liked her because she showed him pretty pictures of herself. R1 stated she allowed R2 to lay on her bed with her but stated she did not want anything sexual to happen, did not want to kiss, and kept saying no. R1 told R2 she never wanted to have sex with him and R2 was shocked and asked, Never? R1 said no, she was gay and was not interested in any man. R1 told R2 she didn't like any penis, and R2 kept saying R1 might like to see it, and then R2 exposed himself and told R1 she had never tried sex with him, and she might like it. R2 reached across R1, who was lying on her bed and, He used that opportunity to kind of grind on me. R1 yelled at R2 and threatened to use the pull cord to summon staff, and R2 left the room. R1 stated she had a long, extensive history of sexual trauma. During an interview on 11/20/25 at 11:59 a.m., R2 stated R1 invited him to lay on her bed with her, showed him her stomach, and allowed R2 to touch it. R2 asked if R1 had ever been with a boyfriend, and R1 stated she had but it never ended well. R2 stated he didn't know what to do because he was confused after R1 let R2 touch her stomach, so he pulled his pants down, and reached across both R1 and the bed to look for something. R2 stated R1 told him to leave or R1 was going to pull the call light to get staff assistance. R2 stated he took that seriously and left the room. R3R3's annual MDS dated [DATE] indicated intact cognition and diagnoses that included anxiety, borderline personality disorder, and depression.R3's care plan dated 1/23/17 indicated a risk and/or history of sexual victimization with an update on 11/17/25 to notify staff of distressing interactions, use her pull cord to get help from staff as needed, and to discuss safety<br>(continued on next page) |

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| | 24E116 | A. Building<br>B. Wing | 11/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Andrew Residence | 1215 South 9th Street<br>Minneapolis, MN 55404 |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | planning weekly and as needed.R3's IPS assessment dated [DATE], indicated R3 struggled to set appropriate boundaries and had a history of sexual abuse.R3's progress notes dated 11/17/25, indicated R3 reported R2 walked across her room naked to close the door when he was visiting R3's roommate, and then later, she was left alone with R2, and R2 engaged in inappropriate sexual conversation with R3 and he exposed himself, which made R3 very uncomfortable. R4R4's quarterly MDS dated [DATE] indicated moderate cognitive impairment and diagnoses that included depression, anxiety, and schizoaffective disorder (a chronic mental health condition that combines symptoms of schizophrenia-a thought disorder such as delusions and hallucinations with symptoms of a mood disorder like bipolar disorder or depression.)R4's care plan dated 6/11/25, indicated risk and/or history of sexual victimization. On 8/15/25, the care plan indicated staff would monitor for interactions in common spaces between R4 and R2 and intervene to assist R4 in setting boundaries, and on 11/12/25, the care plan was updated with an intervention to restrict R2 from R4's residential floor.R4's IPS assessment dated [DATE], indicated a history of physical and sexual abuse and R4 as a victim of sexual exploitation. R4's progress notes indicated the following:-11/12/25 at 10:37 p.m., indicated R2 embraced R4 in R4's room doorway and staff intervened due to R2's history of poor boundaries. R4 reported R2 kissed R4 on the cheek and it was unwanted, and the same behavior occurred a few times in the previous week. Staff discussed boundary-setting with R4, and R4 acknowledged difficulty setting boundaries. Prior to this incident, R4 was observed to be spending time with R2, and reported that the relationship was consensual and that she had the ability to place boundaries. When asked about her safety, R4 confirmed feeling safe and did not express any concerns related to this. She expressed general annoyance and frustration with R2's clinginess.-11/13/25 at 6:53 a.m., indicated R4 was on shift checks due to an uncomfortable interaction with her peer.-11/13/25 at 2:40 p.m., indicated R4 requested a meeting with staff and indicated she was unable to maintain boundaries with R2 and asked for staff assistance to maintain distance from R2. An intervention was added to R2's care plan to restrict R2 from R4's residential floor. A state agency reported five-day report from the facility dated 11/18/25 at 2:18 p.m., indicated R3 (via a confidant) reported on 11/17/25 that on 11/16/25, R2 exposed himself to her after he had consensual sex with R3's roommate and her roommate had left the room. R3 reported R2 additionally exposed himself to her several days earlier. The report also stated R2 was involved in an incident on 11/12/25 where he kissed R4 without permission. Additionally, the report indicated on 11/12/25 R2 kissed R4 without permission. During staff follow-up discussions with R2, R2 displayed limited insight into the impact and distress caused by exposing himself to another resident and acknowledged exposing himself after R1 explicitly told him she did not want to engage in sexual relations with him. During an interview on 11/19/25 at 2:50 p.m., R4 stated R2 tried to kiss her on two different occasions. The first was when R2 asked R4 to come to his room to show R4 his TV but then R2 wouldn't stop touching or kissing R4. After that incident, R2 was banned from R4's residential floor (3rd floor) (progress notes indicate this occurred 11/12/25). R4 stated the second incident was when R2 kissed her in the hallway outside her room, R4 said no, R2 kissed her again, and staff intervened. R4 stated R2 was supposed to be banned from her floor but was there anyway (progress notes indicate this occurred 11/13/25). During an interview on 11/20/25 at 11:59 a.m., R2 stated he kissed R4 on the cheek, R4 said no and R2 kissed R4 again. R2 confirmed he was already restricted from being on R4's residential floor from a different incident but had forgotten about the restriction and went there anyway. R2 stated he was not allowed to have sexual relations with women in the facility, and stated, They [staff] are acting like it was all my fault, like I am a hungry, thirsty, sex fiend just looking to f**k. They [the female residents] wanted to be friends and invited me over. During an interview on 11/19/25 at 4:55 p.m., R3 stated R2 exposed himself to her twice, but could not recall the dates (second incident 11/16/25 via report from confidant, other date unknown). R3 stated she was in the room when R2 and her roommate, were together, R2 walked across the room with his penis exposed, and didn't say anything to R3 at the time. The second incident was after R2 and R3's roommate had sex with R3 in the room. Afterwards<br>(continued on next page) |

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| | 24E116 | A. Building<br>B. Wing | 11/25/2025 |

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| Andrew Residence | 1215 South 9th Street<br>Minneapolis, MN 55404 |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | her roommate left the room, and R2 exposed himself to her (R3). R3 stated she was uncomfortable with the incident, she didn't want to see R2's penis, was afraid of R2 and that he, Would try something with me. R3 stated R2 asked her personal questions, asked if she wanted to touch it or suck it (penis), and she told R2 she did not want to. R3 then stated R2 put his penis away, but stayed in the room, sat on her bed, and continued to make her feel uncomfortable so she thought R2 still wanted something from her.During an interview on 11/20/25 at 11:59 a.m., R2 stated he had been having sexual encounters with R3's roommate, and afterwards she left the room he was alone with R3. R2 asked to sit on R3's bed, asked R3 if she ever had sex with someone and if she thought about having sex, and offered to show R3 his penis. He indicated she said no, but he still thought maybe she wanted to see it, so he took his penis partially out of his pants and R3 looked. R2 then asked her if she wanted to see the rest of it, and since R3 didn't say no, he took his penis fully out of his pants. R2 stated it was his duty to ask if R3 was uncomfortable but hadn't and thought R3 looked confused and uncomfortable. R2 put his penis back in his pants and left the room.During an interview on 11/21/25 at 9:11 a.m., program manager (PM)-A stated she was informed of the incident involving R1 from SW-B but was unsure of the date. The PM-A stated if someone made sexual advances towards a resident, staff should interview the resident, inquire if they needed additional support, perform an investigation, and make a State Agency report. Adding If it were her, she would report advances right away. When in doubt, report and then look into it right away. We would want immediate action. During an interview on 11/21/25 at 9:39 a.m., SW-B stated she was informed R2 forced himself into R1's room and tried to force himself on her on 11/14/25. SW-B stated staff should have interviewed R1 on 11/7/25, when they knew of the incident and should have contacted her mental health providers on 11/7/25 as well. SW-B stated it sounded like a traumatizing experience, but especially so with R1's history. SW-B indicated R1 may not have the capacity to consent for sexual contact and may not be able to consent well due to impulsivity and making decisions to distract from her own feelings.During an interview on 11/20/25 at 1:34 p.m., the PD-A stated she became aware of the incident involving R1 on 11/13/25, when SW-A informed her about the report from FM-A received on 11/7/25. The PD-A stated the primary focus and direction around the event was R1 had asked the person to leave, and they did, but the facility needed to know more about the unwanted touch before it was reportable to the SA. The PD-A stated the expectation was for SW-A to get clarification with R1's treatment team immediately about who would follow up. The PD-A acknowledged no one followed up, the incident was not relayed to other staff, the incident should have been investigated sooner. The PD-A stated she was not sure a full-on investigation was needed, but the facility needed more details, and if the follow-up had occurred on 11/7/25, interventions could have been implemented to protect R1 and other residents. PD-A stated after the facility had more information the State report was filed on 11/13/25. PD-A acknowledged she didn't think any staff had investigated or asked R1 what happened or who was involved from 11/7/25 to 11/13/25. During an interview on 11/20/25 at 12:49 p.m., the mental health worker (MHW)-A stated staff was doing hourly checks on R2 due to multiple incidents with other residents and demonstrated compliance with the hourly checks with the staff signature sheets for the checks, except one missed check on 11/19/25 at 3:00 p.m.The Vulnerability Adult Reporting Policy and Procedure dated 9/28/22, indicated when there are occurrences of resident - to - resident abuse, the facility shall take immediate action to protect the resident(s) involved.The policy stipulates abuse included sexual abuse, and is willful, meaning the individual acted deliberately, and is any non-consensual contact of any type with a resident.Any facility associate who has knowledge of the maltreatment of a resident, or has a reasonable cause to believe that a resident has been maltreated, shall immediately make a verbal report to the supervisor or person in charge and complete an incident report. The person in charge shall inform the administrator. Allegations of abuse shall be reported immediately, but not later than 2 hours after the allegation is made or after forming the suspicion to the State Agency. Reporting is a two-step process, initially reporting and then submitting an investigative report, within 5 working days of the incident.After an internal report of maltreatment<br>(continued on next page) |

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| | 24E116 | A. Building<br>B. Wing | 11/25/2025 |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | is made, the Director of Clinical Services shall investigate the incident. The immediate jeopardy that began on 11/7/25 was removed on 11/21/25, when it was verified, the facility completed the following actions:-Reviewed and revised policies and procedures related to reporting and investigating allegations of abuse and neglect.-Educated all staff and leadership on the above policies and procedures with competency before next shift worked.-Interviewed all residents R2 had access to, including residents on other floors. -Identified a plan to assess and monitor female residents with impaired cognition for possible abuse.-Identified a care plan intervention for medication non-compliance to ensure adequate safeguards are in place related to sexual defiance/deviation. |