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	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Andrew Residence	1215 South 9th Street 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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50762 Based on observation, interview, and document review, the facility failed to conduct regular inspections of hospital bed frames, mattresses and bed rails as part of a preventative maintenance program for 1 of 1 resident (R49) reviewed who had a broken bed rail affixed to the frame. Findings Include: R49's quarterly Minimum Data Set (MDS) dated [DATE], identified R49 had severe cognitive impairment and was independent with all activities of daily living. R49's diagnoses sheet printed 8/1/24 listed the pertinent diagnoses of undifferentiated schizophrenia (experiences psychotic symptoms) and lymphedema (swelling caused by buildup of lymph fluid). R49's care plan dated 6/14/23, indicated R49 was at risk for falls with an intervention of utilizing a hospital bed (electric adjustable bed) with transfer assist bars for sleeping. During observation on 7/29/24 at 3:05 p.m., R49's bed had two pivoting assist devices (PAD) attached to the adjustable bed frame. The left PAD was in the upright position. The right PAD was swung down where the top of it was touching the floor. The right PAD was not in the line with the frame and pulled away from the bed. The PADs were connected to the bed frame by one bolt and utilized a pivot stop handle (pull out to rotate) as the locking mechanism. During observations on 7/30/24 at 7:57 a.m. and 12:52 p.m., the PAD positions remained unchanged. During interview on 7/31/24 at 8:10 a.m., registered nurse (RN)-A verified the right PAD was broken and did not know how long it was in that condition. RN-A confirmed staff round in the rooms daily and someone should have seen this. During interview on 7/31/24 at 9:38 a.m., maintenance engineer (ME)-A stated there were no scheduled maintenance checks for R49's bed and they kept no logs. ME-A stated the normal process was to wait on a call from the floor to address concerns. ME-A stated that the right PAD on R49's bed was broken due to a sheared bolt. (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: 24E116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up observation and interview on 7/31/24 at 10:46 a.m., ME-A was tightening the bolt on the left PAD on R49's bed. ME-A stated they had not reviewed the manual first and they do not have the manual because the director of nursing (DON) does. When asked about proper installation of the left PAD, ME-A replied, I don't know, it's just bolts. During interview on 8/1/24 at 8:07 a.m., the account manager (AM)-C for Direct Supply was unable to verify how often the Direct Supply Panacea 1000 adjustable-Height Low Bed and Direct Supply Panacea Pivoting Assist Device should be inspected. AM-C stated they would have to reach out to their manufacturing group to find out what periodic meant from the user manual. A clarification call-back was requested but not received. During interview on 8/1/24 at 9:30 a.m., the DON stated the bed went in use the same date as the care plan intervention, 6/14/23. A bed maintenance policy and maintenance bed inspection logs were requested but were not received. Owner's manual regarding Direct Supply Panacea 1000 Adjustable-Height Low Bed dated 8/13, recommended periodic inspections which included inspecting all bolts and fasteners and visual examination of all bed components for damage or excessive wear.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview, and document review the facility failed to ensure resident call light was within reach from the bathroom floor in a multi -resident bathroom for 3 of 3 residents (R135, R193, R39,) reviewed for call light accessibility. Findings include: R135 R135's quarterly Minimum Data Set (MDS) dated [DATE], identified R135 had intact cognition and diagnosis which included seizure disorder, anxiety, and schizophrenia. MDS identified R135 was independent with activities of daily living (ADL's) which included transfers, toileting, and showering. R135's fall risk assessment dated [DATE], identified R135 was a moderate risk for falls related to medication use. Further identified R135 had three falls in the past year, one with an injury from striking her head. R135's care plan dated 12/10/21, identified R135 was at risk for falls related to medication use and history of falls. Care plan instructed to encourage use of emergency call-light system as needed, for immediate and urgent staff assistance. During an observation on 7/29/24 at 7:00 p.m., the multi-resident bathroom was noted to have a call light on the wall to the right side of the shower with a cord that that was approximately three feet from the floor and a call light on the wall to the left side of the toilet with a cord that was approximately two feet from the floor. During an observation on 7/30/24 at 8:22 a.m., the multi- resident bathroom continued to have a call light on the wall to the right side of the shower with a cord that that was approximately three feet from the floor and a call light on the wall to the left side of the toilet with a cord that was approximately two feet from the floor. During an interview on 7/30/24 at 11:34 a.m., R135 confirmed she used the toilet and shower independently in the multi-resident bathroom. R135 stated she would not be able to reach the emergency call light if she fell on the floor while using the toilet or the shower. R135 stated she had a history of falls and should have access to a call light if she were to fall on the floor while in the bathroom. R193 R193's quarterly MDS dated [DATE], identified R193 had intact cognition and diagnosis which included post-traumatic stress disorder (PTSD), anxiety, and schizophrenia. MDS identified R193 was independent with activities of daily living (ADL's) which included transfers, toileting, and showering. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R193's fall risk assessment dated [DATE], identified R193 was a high fall risk related to functional impairments and a fall in the past 30 days. Further identified R193 was not able to transfer safely or safely sit in a shower/tub chair. R193's care plan dated 3/19/24, identified R193 was at significant risk for falls related to medication use and obesity. Care plan instructed to encourage use of emergency call-light system as needed, for immediate and urgent staff assistance. During an interview on 7/30/24 at 11:39 a.m., R193 confirmed she used the toilet independently in the multi-resident bathroom and at times used the shower in the multi-resident bathroom independently. R193 stated she would not be able to reach the emergency call light if she fell on the floor while using the toilet or the shower. R193 stated she had a history of falls and feels it was important for her to be able to reach the call light from the floor in the bathroom. R39 R39's quarterly MDS dated [DATE], identified R39 had intact cognition and diagnosis which included schizophrenia, asthma, and hyponatremia (low sodium blood levels). MDS identified R39 was independent with activities of daily living (ADL's) which included transfers, toileting, and showering. R39's fall risk assessment dated ,d+[DATE], identified R39 was a moderate risk for falls relation to medication use. R39's care plan dated 9/14/21, identified R39 was at risk for falls related to clutter. Care plan lacked evidence of the use of the emergency call system. During an interview on 7/30/24 at 11:44 a.m., R39 stated she used the toilet independently in the multi-resident bathroom. R39 stated she was unsure if she would be able to reach the call light if she was on the floor in the bathroom but felt it was important for her to be able to reach the call light from the floor in the bathroom. During a joint interview on 7/30/24 at 12:10 p.m., mental heath worker (MHW) and licensed practical nurse (LPN)-A verified R135 and R193 were all fall risk and used both the toilet and the shower independently in the multi-resident bathroom and R39 was also a fall risk and used the toilet independently in the multi-resident bathroom. MHW and LPN-A stated all three residents were able to use the call system but would not be able to access the call light system if they were on the floor in the bathroom. During an interview on 7/30/24 at 3:07 p.m., director of nursing (DON) stated call lights may not be within reach in the multi- resident bathroom if R135, R193, or R39 were on the floor. [NAME] further stated she was unsure if there was a need for a resident to be able to access the call light from the floor because of the highly ambulatory population of the residents. A facility policy titled Emergency Monitoring System dated 4/23/14, identified pull station transmitters were located in resident rooms, bathroom, and other common areas. Further identified all activations of the system shall be responded to in a timely fashion by staff members.