STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redeemer Residence Inc	625 West 31st Street Minneapolis, MN 55408

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42584 Based on observation, interview, and document review, the facility failed to ensure a self administration of medications (SAM) assessment was completed to allow residents to safely administer their own medications for 3 of 3 (R66. R6, and R73) residents observed with medications at bedside. Findings include: R66's annual Minimum Data Set (MDS) dated [DATE], indicated R66 had modified independence -some difficulty in new situations only- regarding cognitive skill for daily decision making. The MDS further indicated R66 required set up only to extensive assistance for all activities of daily living (ADLs). R66's diagnoses included traumatic brain injury, major depressive disorder, anxiety, opioid dependence, asthma, gastro-esophageal reflux disease (GERD), spinal stenosis, and chronic obstructive pulmonary disease (COPD). R66's care plan indicated R66 had altered respiratory status related to asthma and at risk for nutritional status related to GERD. R66's care plan lacked evidence of self-administration of medications (SAM). R66's order dated 11/22/21, indicated levalbuterol tartrate-inhaler 45 mcg/actuation, 1 puff every four hours as needed. R66's order dated 7/15/22, indicated tamsulosin, 0.4 mg capsules, amount to take two capsules daily within 30 minutes after the same meal each day. Neither order indicated R66 could self-administer the individual medications. Further, R66's orders lacked evidence of a blanket self-administration order allowing R66 to keep medications at bedside or administer to self unsupervised. R66's SAM assessment dated [DATE], indicated R66 did not want to self-administer or was not currently self-administering medications based on previous assessment. During observation and interview on 4/9/24 at 1:13 p.m., R66 was in his room without staff present waiting to be taken to the shower. He stated he had eaten lunch already and that it was okay. There was a levalbuterol tartrate inhaler on the bedside table and a medicine cup with two unidentified capsules each with 0.4 noted on them. R66 stated he often self-administered his inhaler, nebulizer, or other medications. (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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on at 4/9/24 at 1:52 p.m., registered nurse (RN)-F confirmed the presence of the inhaler and capsules at R66's bedside. RN-F identified the capsules as tamsulosin and stated that medication was due and would have been provided at noon today and should be taken within 30 minutes after his meal. RN-F stated residents must have an order and current assessment to identify the resident was safe for SAM to leave them at the bedside. R66's oral intake report for 4/9/24, indicated R66 ate 76-100 percent of his lunch meal and documented at 12:36 p.m. During interview on 4/9/24 at 2:25 p.m., RN-C stated residents must have an order and assessment for SAM and that it should also be care planned. RN-C verified R66 did not have a current order or assessment for SAM nor was it addressed in the care plan. RN-C stated medications should not be left at the bedside without the appropriate order and assessment in place. RN-C further stated the tamsulosin should be taken within 30 minutes of a meal and should not have been left at the bedside. During interview on 4/9/24 at 2:45 p.m., director of nursing (DON) stated expectation was that a resident would have an order and an assessment for SAM and that it would be care planned to ensure a resident could safely self-administer medications. 42580 Findings include: R6 R6's quarter Minimum Data Set (MDS) dated [DATE], indicated R6 was cognitively intact, and received antidepressants. R6 diagnosis included anxiety disorder and depression. R6's care plan updated 4/4/24, indicated problem included cognitive loss dementia with decision making impaired related to dementia with depression, and short term memory loss. Intervention included observe for changes and decline in mental status and give instructions one step at a time. R6's physician orders dated 3/11/24 to 04/11/24, lacked a SAM documentation. R6's quarterly SAM assessment dated [DATE], indicated R6 did not want to self-administer her medications. During medication pass observation and interview on 4/10/24 at 7:23 a.m., trained medication assistant (TMA)- dispensed amlodipine 5 milligrams (mg), tablet; Bupropion 150 mg tablet; metformin 500 mg, and vitamin D3 25 microgram into medication cup. TMA- then went to the dining room with R6's medication then placed the medication on dining room table in front of R6. TMA- then left the medications on the dining table and left them in the medication cup in front of R6. TMA- then left to go to medication cart before R6 took the medications. TMA- stated R6 knew how to take her own medications independently when medications were left with her, without issues. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/11/24 at 9:32 a.m., director of nursing (DON) checked electronic health record and verified R6's SAM assessment did not include a self-administration of medication. DON also verified R6 physician orders lacked a SAM order. DON further clarified R6 should be supervised during medication pass and staff were to ensure R6 medications were swallowed before staff left R6 and medications should not be left with resident on dining table. 49617 R73 Findings include: R73's quarterly Minimum Data Set (MDS) dated [DATE], indicated he had intact cognition and had diabetes, high blood pressure, low sodium levels, and gastro-esophageal reflux disease (acid reflux or heartburn). MDS also indicated R73 was independent with eating and activities of daily living (ADL). A self-administration of medication assessment dated [DATE] indicated R73 did not want to self-administer medication. A self-administration of medication assessment dated [DATE] indicated R73 did not want to self-administer medication. A self-administration of medication assessment dated [DATE] indicated R73 did not want to self-administer medication. R73's physician orders included the following: - lipase-protease-amylase (Creon) capsule, delayed release; 24,000-76,000 - 120,000 unit; Give 4 capsules by mouth with lunch and dinner to treat gastro-esophageal reflux disease, dated 10/1222. - lactase (Lactaid) tablet, 3,000 unit; Give 9,000 units by mouth with meals to treat gastro-esophageal reflux disease, dated 10/12/22. - Ok to self administration [sic] once nursing set up, dated 1/30/23. R73's care plan, dated 12/21/22, indicated he wished to self-administer the following medications: acetaminophen, aspirin, Centrum Silver Ultra Men's, cholecalciferol, Creon, Crestor, famotidine, Lactaid, lisinopril, ferrous sulfate and Tums. The care pan indicated R73 had been assessed and was appropriate for self-administration of those medications. The interventions identified included completing self-administration of medications observation per protocol, following physician's orders for medications that can be self-administered, and nurse to provide set-up of medications for resident. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 4/8/24 between 4:51 p.m. and 5:11 p.m., R73 was sitting on his bed with the bedside table in front of him. There was a medication cup with two oblong white tablets and four capsules that were red with brown beads inside. There was no staff in the room. R73 stated he usually took those medications on his own with meals. At 5:01 p.m., trained medication assistant (TMA)-B entered the room and verbalized being unsure if R73 had an assessment or orders for self-administration of medications. TMA-B stated R73's orders would be reviewed and left the room. At 5:11 p.m., TMA-B re-entered the room and stated R73 had a recent order for self-administration of medications. During interview on 4/10/24 at 12:17 p.m., registered nurse (RN)-A stated to determine if a resident was able to safely administer their own medications, a self-administration of medication assessment should be completed by nursing staff. If the resident was found to be capable of safely administering their own medications, RN-A stated the resident's provider would be contacted next for an order. RN-A stated residents would need both the assessment and the provider's order for self-administration. RN-A was unaware of R73 having an assessment and stated, we should not be leaving his medications there with him. RN-A reviewed R73's chart and verified his self-administration of medication assessment dated [DATE], indicated R73 was not safe to administer his own medications. Additionally, RN-A reviewed the self-administration assessments dated 12/28/23 and 918/23 and verified both assessments indicated R73 was not safe to administer his own mediations. RN-A stated, it would be safest to not have him self-administer. Facility policy last reviewed 3/4/24, indicated, If the resident wishes to self-administer medication, complete the applicable observation/assessment in the EHR [electronic health record]. If the resident was assessed able to [SAM] then they must Obtain an order from the provider that the resident may SAM. Order should indicate which mediation will be self-administered. Further, Information regarding [SAM] will be added to the care plan.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42584 Based on observation, interview and document review, the facility failed to ensure the call light was accessible for 1 of 1 resident (R39) reviewed for accommodation of needs. Findings include: R39's quarterly Minimal Data Set (MDS) dated [DATE], indicated R39 had moderate cognitive impairment, required substantial/maximal assistance with most activities of daily living (ADLs), was dependent on staff for toileting, transfers, and personal hygiene. R39's diagnoses included dementia, renal disease, diabetes, and congestive heart failure. R39's care plan last reviewed 3/27/24, indicated R39 was at risk for falls and instructed staff to make sure call light was within reach. R39's progress note dated 1/14/24, indicated R39 had an unwitnessed fall from bed. R39's falls risk assessment dated [DATE], indicated R39 was at moderate risk for falls and instructed staff to ensure call light was within reach and remind him not to reach for things. During observation and interview on 4/8/24 at 2:32 p.m., R39 was in bed with the call light was on the floor under his bed. R39 attempted to reach the call light and was unable to do so. During interview on 4/8/24 at 2:39 p.m., nursing assistant (NA)-E stated the call light should not be under the bed and should be within R39's reach. NA-E further stated the call light cord normally had a clip to be used to clip to the resident, however, R39's call light was missing the clip. NA-E left R39's room to retrieve a clip and attached to R39's call light cord. NA-E further stated R39 had fallen out of bed previously and should not have to reach for any items. During interview on 4/10/24 at 1:30 p.m., registered nurse (RN)-C stated staff should ensure all call lights were within reach for those residents who could use them. If a resident was unable to use a call light, staff would complete service rounds to ensure resident needs were met. RN-C stated R39 could use the call light. During interview on 4/10/24 at 1:44 p.m., director of nursing (DON) stated expectation was staff would ensure all call lights were within reach for all residents. Facility policy Call Lights dated 10/22/2023, indicated, Place call light so it is accessible to the resident at all times when in resident room. Secure the call light to stay within access of the resident.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Resident #83 Based on interview and document review, the facility failed to contact the designated representative and gain consent for medical treatment for 1 of 1 residents (R83) reviewed for notification of change. Findings include: R83's quarterly Minimum Data Set (MDS) dated [DATE], indicated he continuously had altered levels of consciousness and was rarely or never understood. MDS indicated R83's diagnoses included Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills) and dementia (a loss of memory, language, problem-solving and other thinking abilities). MDS indicated R83 was dependent on staff for assistance with activities of daily living (ADL), mobility, and transfers. R83's medication administration record dated 12/2023, indicated oseltamivir (Tamiflu) 75 milligrams (mg), an antiviral medication used to prevent or treat influenza, was administered from 12/8/23 through 12/21/23. R83's care plan dated 4/14/22, indicated he was at risk for decline and identified interventions of administering medications and treatments per provider order in addition to monitoring for changes and notifying his provider and representative. A provider progress note dated 12/12/23, indicated R83 received Tamiflu prophylactically (preventatively) due to an outbreak of influenza in the facility. A progress note dated 1/6/24 indicated after a conversation with R83's family member (FM), staff would contact the FM prior to any new medical interventions and treatment. The progress note also indicated copies of R83's power of attorney (POA) agreement naming the FM as the responsible party. R83's electronic health record (EHR) lacked documentation that demonstrated staff updated his FM about administration of Tamiflu. During interview on 4/9/24 at 3:37 p.m., R83's FM verbalized dissatisfaction with pushback from staff regarding decisions made by them not to prolong R83's life. The FM stated they were R83's healthcare POA and reported the facility had not notified them or gained their consent prior to administering Tamiflu to R83. The FM stated, I was appalled. During interview on 4/10/24 at 10:46 a.m., registered nurse (RN-E) stated they would update a resident's legal guardian or POA if a resident had a change in status and document that in a progress note. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/11/24 at 9:58 a.m., RN-B stated for any change in status, staff were expected to update the family, especially if a resident had a POA. RN-B stated nurses were expected to document those conversations in the resident's chart. Additionally, RN-B stated staff were always expected to get consent, including for preventative healthcare measures. RN-B verified R83 received Tamiflu as part of a preventative measure. RN-B stated, we made a mistake, we gave him the Tamiflu. RN-B stated R83's FM found out after receiving a bill and was not okay with it. RN-B explained how, moving forward, for R83's care, for any new treatment or any changes to current treatments, staff would be contacting his FM. During interview on 4/11/24 at 10:29 a.m., the director of nursing (DON) stated the facility routinely informed resident's and their representatives of the risks and benefits of all interventions in the care plan during care conferences and as needed in between. The DON stated the process to inform a resident and their representative included providing education, ensuring interventions are clinically indicated, and gaining consent. The DON verified R83 received Tamiflu as ordered by the facility's medical director during an outbreak. The DON stated staff notified resident's and their representatives, however, the facility did not have a copy of R83's POA paperwork at that time. The DON stated, we made a mistake. I think the issue was we didn't have paperwork at the time. A facility policy titled Change in Condition, dated 12/31/18 and last reviewed 3/28/24, indicated notifications will be made withing twent-four (24) hours of a change occuring in the resident's medical/mental condition or status except in medical emergencies. Additionally, the policy indicated regardless of the resident's current mental or physical condition, a nurse or healthcare provider will inform the resident of any changes in his/her medical care or nursing treatments.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44651 Based on observation, interview, and document review, the facility failed to draw privacy curtains or close the residents door during personal cares, making a resident feel their personal privacy was not being protected for 1 of 1 resident (R1) reviewed for personal privacy and confidentiality. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], included R1 was cognitively intact, dependent on staff for transfers and toileting, and required moderate assistance with upper body dressing and maximal assistance for lower body dressing. R1 had diagnoses of quadriplegia, anxiety, and neurogenic bladder. R1's care plan dated 4/3/23, included R1 required extensive assist of two staff for bed mobility, 1-2 staff for dressing and toileting, and assist of two staff for transfers using a full body mechanical lift. During interview on 4/8/24 at 2:52 p.m., R1 stated they had a roommate and did not get enough privacy. They stated recently they were receiving personal cares and the nursing assistant (NA) needed to leave the room, and they left R1 lying on their bed, uncovered, and undressed wearing only a brief, with the privacy curtain open. They indicated the room door did not close completely, and R1's roommate's family entered the room while R1 was exposed, leaving her embarrassed and angry. During interview on 4/10/24 at 8:25 a.m., nursing assistant (NA)-B stated they pulled the privacy curtain around the resident's bed to make them feel secure during cares, and ensured residents were covered if they needed to leave the room for anything in case someone came into the room. During interview on 4/10/24 at 8:30 a.m., NA-C stated privacy curtains should be pulled during cares, and if staff needed to leave, they finished cares first and left the resident with the call light. During observation on 4/10/24 at 1:45 p.m., R1 was visible from the hallway as they were lying in bed in their room. They wore a hospital gown which was pulled up to their brief, had a catheter bag lying on their bed, and had a mechanical lift sling under their body and attached to the lift. Both the privacy curtain and the room door were open, and the bedding was pulled down to the end of the bed leaving R1 uncovered. A sign on the door requested staff to close the door completely. During interview on 4/10/24 at 1:51 p.m., registered nurse (RN)-A left R1's room with the mechanical lift. RN-A confirmed the door, and the curtain were both open upon their arrival to R1's room, and they should have reminded NA-D to close the curtain when leaving a resident in that state to protect their personal privacy. During interview on 4/10/24 at 2:01 p.m., NA-D confirmed they left the room to go get another staff person to assist with using the mechanical lift but did not comment on the open door and open curtain. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/11/24 at 8:17 a.m., director of nursing (DON) stated resident should not be left exposed in their room unless it was a personal preference and should be covered to protect their privacy. The facility Resident Rights policy dated 3/5/24, included residents had the right to have privacy in treatment and in caring for personal needs.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22580 Based on interview and document review, the facility failed to ensure a baseline care plan was reviewed and provided timely to ensure knowledge of care and promote person-centered care planning for 1 of 2 residents (R74) reviewed for care planning. Findings include: R74's face sheet undated, indicated R74 admitted to the facility 1/12/24, was readmitted to the hospital on 1/30/24, and readmitted to the facility on [DATE], was readmitted to the hospital on 3/15/24 and readmitted to the facility on [DATE]. R74's admission cognition assessment dated [DATE], indicated R74 was cognitively intact. R74's diagnoses list indicated R74's diagnoses included end stage renal disease, diabetes mellitus, dependence on renal dialysis, depression, long term use of insulin, nicotine dependence and bipolar disorder. R74's baseline care plan initiated 1/18/24, included pain, psychotropic medications, falls, skin, medical conditions, dialysis, and discharge plan. During interview on 4/9/24 at 8:54 a.m., R74 indicated she was not included on any planning or what the expectation for her stay or discharge planning were. She denied having a care conference or being invited to a care conference, or being provided anything verbally or in writing regarding her cares. During interview on 4/11/24 at 8:15 a.m.,Licensed Social Worker (LSW) -A and Social Service Director stated an initial care conference should be held by day 7. LSW-A verified a 48 hour care plan was not given to R74 and no care conference was held. LSW-A indicated she had just taken over R74's case last week, and verified the previous LSW had not completed the care conference. The facility policy: Care conferences and 48 Hour Care Plan Summary & Baseline Care Plan dated 3/18/2024, indicated, Care conferences will be held for TCU/Short stay residents as soon as possible but not later than 21 days after admission. Care conferences are held quarterly and with significant change in status thereafter. Care conferences for Long term care residents will be held within 21 days of admission and quarterly and with significant change in status thereafter. Social service staff (or designated facility staff) will invite resident and representative to care conferences. If resident is on hospice, hospice will be invited to care conference. If resident is on dialysis, dialysis will be invited to care conference. If resident has a case manager, they will be invited to the care conference.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 44651 Based on observation, interview, and document review, the facility failed to accurately assess and monitor multiple non-healing and bleeding skin lesion, lacerations, and scabs for 1 of 1 resident (R40) reviewed for non-pressure related skin conditions. Findings include: R40's significant change Minimum Data Set (MDS)-dated 3/6/24, indicated they were cognitively intact, had diagnoses of heart failure, peripheral vascular disease, kidney failure, diabetes, and lower limb amputation. R40 was dependent on staff for showers, dressing, personal hygiene, and transfers, and was at risk for pressure ulcers but had no unhealed pressure ulcers or arterial or venous ulcers. R40's care plan dated 1/23/24, indicated R40 had an alteration in skin integrity, and instructed licensed staff to complete visual body observation weekly, implement appropriate interventions for any areas of concern, and notify provider and family of any new areas of concern. In addition, nursing assistants were directed to observe skin daily during cares and notify nurse promptly of any areas of concern. The care plan lacked identification of R40's recurrent skin lesions on their arms, legs, and chest in addition to interventions. A provider note dated 2/6/24, indicated R40 has multiple small, circular superficial lesions of both upper extremities. R40's Visual Body Inspection forms dated 3/10/24, 3/17/24, 3/24/24, 3/31/24, and 4/7/24, all indicated R40 had no new skin concerns noted. R40's Physician Order Report dated 4/11/24, included orders for: - Weekly wound assessment, measure and record characteristics of skin alterations noted under wound management tab, add new entry under each wound, and mark healed if skin alteration is healed. The order included special instructions to Ensure all wounds under wound management are updated starting 2/5/24. - Clean upper extremities with Vashe (a wound cleanser) then apply a nickel thick layer of santyl (a prescription cream to help heal burns and ulcers), cover with adaptic (a non-adherent dressing) followed by roll gauze then tubigrip (a tubular dressing) daily starting 2/23/24. - Bath/shower Sunday morning, notify nurse to do body audit starting 2/26/24. R40's Wound Management Detail Report dated 4/11/24, identified R40's left ring finger scab as healed on 3/6/24, and skin concerns on the left second finger and right hand as healed on 3/28/24. The medical record lacked identification and monitoring of the numerous current open areas and scabs on R40's left and right arms. (continued on next page)

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	245520	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redeemer Residence Inc	625 West 31st Street Minneapolis, MN 55408

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 4/8/24 at 6:35 p.m., R40 was seated in their wheelchair in their room with a loose, soiled bandage wrapped around their right arm which was falling off toward their hand and had paper towels tucked underneath and no tubigrip. Several small round sores were visible above the dressing on the right arm. R40's left arm and hand had approximately 20 red sores and scabs of sizes up to approximately 3/4 of an inch, some appearing new and others in various states of healing. R40 stated most of the spots were blisters, and staff put dressings on the right arm but did not assess or treat the sores on the left other than applying a regular moisturizing lotion as they did the rest of their body. They identified they had some additional sores on their left hand from getting it caught in the wheel of the wheelchair a few weeks earlier. During observation and interview on 4/09/24 at 8:58 a.m., R40 was lying in bed wearing a hospital gown with blood spots on the top left toward the neck, a wound dressing on the right arm, and numerous visible sores on the left arm. R40 revealed their upper left chest where there was a large bleeding area of multiple sores. R40 stated they scratched themselves sometimes in their sleep. During interview on 4/10/24 at 12:31 p.m., nursing assistant (NA)-D stated NAs observed for skin changes during cares, but nurses completed the full body weekly skin checks on shower day. NA-D stated R40 poked and picked at their sores and staff needed to change the bedding daily due to blood spots. They identified R40 picked off one of the scabs on their left arm that morning and it began bleeding, and all the spots were getting worse. They indicated R40 did not have any special creams or lotions, and they just used the standard skin moisturizing lotion on their skin. During interview on 4/10/24 at 12:40 p.m., registered nurse (RN)-E stated nurses completed a head-to-toe skin assessment on each shower day and completed the documentation in the computer system. If there was open skin, they reported to RN-B and the nurse practitioner and RN-B began a wound assessment including measurements and characteristics and monitored concerns moving forward. They indicated both new concerns and those currently being monitored were identified on the weekly skin assessment form, and wounds were assessment by the wound doctor and RN-B every Thursday. RN-E stated R40 often had itching spells and had an order for hydroxyzine (an antihistamine used to reduce skin itching) as needed, and stated RN-B was monitoring R40's skin. During interview on 4/10/24 at 2:30 p.m., RN-B stated body audits were completed weekly with showers and anything new was documented in the computer. Wounds were documented in a wound management form and assessed weekly by RN-B and the wound doctor, but the wound doctor was mainly focused on pressure ulcers. RN-B stated R40 had chronic skin issues and involuntarily scratched themselves at night and had open areas on their arms and hands that came and went, in addition to one on their upper chest. They stated they were monitoring the one on their chest weekly and indicated they had monitored the ones on their arms in the past, but the sores were hard to keep track of since they were intermittent. Upon review of R40's medical record, RN-B stated the sores on R40's left hand and finger were resolved on 3/15/24, but they could have come back since they were chronic, however RN-B had not seen R40's arms that day. During interview on 4/10/24 at 9:39 a.m., NA-C stated nurses checked residents' skin weekly on shower days to identify any redness or other skin concerns. They stated if the NA found any new issues, they notified the nurse. They indicated R40 had sores on their arms and were not sure if they were improving or getting worse, but R40 picked at them and some days they bled more than others. They indicated they thought R40 had creams for them, but they were not sure. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 4/10/24 at 10:08 a.m., R40 was seated in their wheelchair in their room, arms covered in sores as previously described, with another visible on their right cheek. During interview on 4/11/24 at 8:19 a.m., director of nursing (DON) stated nurses completed and documented weekly head-to-toe skin assessments, and any new concerns were added to the form, and previous concerns were documented in a wound management form by the nurse managers. They indicated the nurse managers should be looking at weekly skin assessments and documenting measurements and characteristics so they could update the provider with any changes, and R40's chronic skin issues should have been recorded in their care plan. The Skin Integrity policy dated 3/8/24, included licensed nurse to complete visual head to toe skin inspection and document on designated area in the medical record. NAR will inspect skin daily with cares and any skin alterations identified will be reported immediately to licensed nurse. Nurse will communicate new skin alterations to the Interdisciplinary team, medical provider, and the resident representative. Nurse will implement appropriate treatment for new skin alterations using wound care protocol or based on provider recommendations, complete a new comprehensive skin risk assessment if area is pressure, arterial, venous, diabetic, neuropathic, or mixed etiology, and document in designated area in electronic medical record related to the skin alteration including specific location of alteration, physical description of alteration and measurements.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42584 Based on observation, interview, and document review, the facility failed to assure properly operational pressure-reducing air mattress were in place as intervention to reduce pressure ulcers for 2 of 3 residents (R39 and R87) reviewed for pressure ulcers. Findings include: R39 R39's quarterly Minimal Data Set (MDS) dated [DATE], indicated R39 had moderate cognitive impairment, required substantial/maximal assistance with most activities of daily living (ADLs), and was dependent on staff for toileting, transfers, and personal hygiene. The MDS indicated R39 was at risk for developing pressure ulcers and required pressure reducing device for bed. R39's diagnoses included dementia, renal disease, diabetes, and congestive heart failure. R39's pressure ulcer/injury care area assessment (CAA) dated 9/29/23, indicated R39 was at risk for developing pressure ulcers due to immobility and incontinence and required a special mattress to reduce or relieve pressure. R39's wound assessment dated [DATE], indicated, Patient has wound on his left medial buttock; coccyx; right heel. Wound assessment further indicated care recommendations to include low air loss mattress. R39's comprehensive skin risk with Braden assessment dated [DATE], indicated R39 was bedfast, or wheelchair bound, had a history of healed pressure injures, and was at moderate risk for skin breakdown. R39's care plan last reviewed 3/27/24, indicated R39 was at risk for alteration of skin integrity and instructed, Pressure redistribution mattress. During observation on 4/8/24 at 2:32 p.m., R39 was lying in bed on top of a deflated overlay air mattress. The pump on the air mattress was not plugged into the wall and therefore not operating. During observation and interview on 4/8/24 at 2:39 p.m., nursing assistant (NA)-E entered R39's room and confirmed the air mattress was not plugged in operating. NA-E stated they were not sure if R39 required the air mattress overlay and left the room to inquire. During observation and interview on 4/8/24 at 2:49 p.m., registered nurse (RN)-C entered R39's room and stated R39 had a history of skin breakdown and required the air overlay to be operational. RN-C confirmed the pump was not plugged in and that it could not reach the outlet with the bed in the current position. RN-C stated R39's bed used to be against a different wall and could not remember when it was moved. R87 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R87's quarterly MDS dated [DATE], indicated R87 had moderate cognitive impairment, and required partial/moderate to substantial/maximal assistance with most ADLs, bed mobility, and transfers. The MDS indicated R87 was at risk for developing pressure ulcers. R87's diagnoses included dementia, depression, history of strokes, and urinary incontinence. R87's pressure ulcer/injury CAA dated 11/24/23, indicated R87 was at risk for developing pressure ulcers due to incontinence and required special mattress to reduce or relieve pressure. R87's comprehensive skin risk with Braden assessment dated [DATE], indicated R87 was bedfast, or wheelchair bound, had a history of healed pressure injures, and was at risk for skin breakdown. R87's care plan last reviewed 3/13/24, indicated R87 was at risk for alteration of skin integrity and instructed, Pressure redistribution mattress. During observation on 4/8/24 at 5:16 p.m., R87 was lying in bed with the air mattress not turned on. During observation and interview on 4/9/24 at 12:59 p.m., R87 was lying in bed watching TV and stated he had been up in the wheelchair for breakfast but would remain in bed the rest of the day. R87's air mattress was not turned on. During observation on 4/10/24 at 7:18 a.m., R87 was sleeping in bed and the air mattress was not turned on. During observation and interview on 4/10/24 at 8:03 a.m., NA-I assisted R87 up to the wheelchair and stripped the linen from his bed. R87's mattress had a concave indentation in the center approximately 8 inches deep. NA-I confirmed the air mattress was not turned on and that indentation was not normal. NA-I stated the R87's air mattress should be turned on whenever he was in bed. During interview on 4/10/24 at 9:18 a.m., RN-G stated R87's air mattress should be plugged in and that there should not be an indentation in the center of the mattress. RN-G stated air mattress was used to prevent skin breakdown. During interview on 4/10/24 at 1:30 p.m., RN-C stated expectation for both R39 and R87's air mattresses would be plugged in, turned on and operational to prevent skin breakdown. During interview on 4/10/24 at 1:44 p.m., director of nursing (DON) stated expectation for residents who required pressure reducing mattresses to prevent skin break down that the mattresses be plugged in and turned on. Facility policy Skin Integrity last reviewed 3/28/24, indicated goal to provide appropriate treatment plans based on resident needs for pressure relief to promote healing or prevent skin injuries from developing. Implementation of care plan and interventions to treat any existing skin related concerns as well as interventions to prevent skin integrity concerns.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44651 Based on observation, interview, and document review, the facility failed to ensure post-dialysis assessment and monitoring was completed for 1 of 1 residents (R40) reviewed for dialysis. Findings include: R40's significant change Minimum Data Set (MDS) dated [DATE], indicated the were cognitively intact, and had diagnoses of kidney failure, high blood pressure, diabetes, heart failure, and peripheral vascular disease. The MDS indicate R40 did not receive dialysis treatments while in the facility. R40's care plan dated 1/6/24, indicated R40 required hemodialysis related to end-stage kidney disease, had a shunt in their left arm for vascular access, and lacked pre- and post-dialysis instructions for monitoring of access site, shunt bruit and thrill, and vital signs. R40's Referral Forms and progress notes dated 3/4, 3/7, 3/11, 3/15, 3/18, 3/20, 3/27, 4/1, 4/3 and 4/8/24, indicated they had dialysis on those dates. No additional forms were included in the medical record. R40's Physician Order Report dated 4/11/24, included orders for staff to check shunt for bruit and thrill on left arm every shift from 1/9/24 - 1/24/24, check vital signs after each dialysis run daily on Mondays, Wednesdays, and Fridays from 1/9/24 - 1/24/24, and remove dressing from dialysis site on the shift after they return from dialysis at bedtime (unless otherwise ordered) on Monday, Wednesday, and Friday from 1/9/24 - 1/24/24. No new orders for monitoring were present. R40's Vitals taken from 3/1/24 to 4/11/24, lacked documentation of post-dialysis vital sign monitoring on 3/4, 3/7, 3/11, 3/15, 3/18, 3/20, 3/27, 4/1, 4/3, and 4/8. R40's Medication Administration Record (MAR) for 3/1/24 - 3/31/24, and 4/1/24 - 4/10/24, lacked evidence of post-dialysis monitoring of access site, shunt bruit and thrill, and vital signs. R40's medical record lacked documentation of post-dialysis monitoring of access site, shunt bruit and thrill, and vital signs on the aforementioned dates. During observation and interview on 4/8/24 at 6:38 p.m., R40 stated they went to dialysis three days per week on Mondays, Wednesdays, and Fridays. They stated vitals signs were completed after dialysis at the dialysis center, but staff did not complete any post-dialysis assessments after they returned to the facility. During interview on 4/10/24 at 12:40 p.m., registered nurse (RN)-E stated staff assessed the dialysis access site and completed a set of vital signs prior to a resident going out to dialysis and documented them in the Vitals section of the chart. They stated there was an order to check the site for bleeding and take a another set of vital signs upon their return from dialysis, however R40's dialysis was scheduled in the afternoon and they did not usually return to the facility until the evening shift staff arrived, so they were unsure if they were being monitored. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/10/24 at 2:30 p.m., RN-B stated the nurses took a set of vital signs prior to dialysis and recorded them in the progress notes, however there was no other assessment required beforehand. They stated a post-dialysis assessment was a standard of care, and staff should check the dialysis access site after dialysis to make sure it's ok, however there was not a specific form to complete. RN-B reviewed R40's medical record and stated R40 had a left arm shunt and a dialysis care plan, however there was no evidence of post-dialysis monitoring of their access site, shunt bruit and thrill, or vital signs. During interview on 4/11/24 at 8:13 a.m., director of nursing (DON) stated residents who had dialysis had an order set placed which prompted staff to check the shunt dressing, bruit and assess vital signs after dialysis treatments, and they should be recorded in the treatment administration record. Upon review of R40's medical record, DON stated it appeared staff were not completing an assessment after R40's dialysis treatment and indicated it would be important to ensure the shunt was functioning properly and there was not excessive bleeding or other complications. The Dialysis policy indicated the facility will provide ongoing assessment of the resident's condition and will monitor for complications before and after each dialysis treatment received at a certified dialysis facility.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42584 Based on interview and document review, the facility failed to provide medically related social services and/or obtain mental health counseling for 1 of 1 resident (R87) diagnosed with major depressive disorder and inappropriate tendencies towards staff reviewed for behavioral services. Findings include: R87's quarterly MDS dated [DATE], indicated R87 had moderate cognitive impairment, and required partial/moderate to substantial/maximal assistance with most activities of daily living (ADLs). The MDS indicated R87 received antidepressant medication. R87's diagnoses included dementia, depression, and had a history of homicidal ideations. R87's care plan (CP) dated 3/13/24, identified R87 was at risk for mood and behavioral disturbance r/t (related to) diagnosis of depression and history of inappropriate sexual behavior. The CP further identified R87 at risk for psychosocial well-being with intervention, Refer to psychologist/psychiatrist as appropriate. R87's PHQ-9 (patient health questionnaire for depressive symptoms) assessment dated [DATE], indicated a score of 0- no depression. R87's provider note dated 12/19/23, indicated R87's mood had been down and was more depressed. The note further indicated, Patient also requested a visit with our in-house psych .and continues [to] be inappropriate with staff, making sexual comments. The note included a plan for, Refer to in-house psych. R87's provider orders dated 12/19/23, indicated, Refer to inhouse psych per patient request for mood disorder. R87's PHQ-9 dated 2/13/24, indicated a score of 9-mild depression. R87's progress note (PN) dated 2/13/24, indicated, Pt admits he thinks of suicide daily because he misses his wife. The PN further indicated, Pt is also seeing Psychiatrist already to address his MDD [major depressive disorder]. R87's care conference summary (CCS) dated 2/28/24, indicated, R87 had behavioral problems, Pt behaviors include sexual comments towards staff and telling others staff is going to kill him. The CCS further indicated psychology services were not offered and last visit date was unknown for all ancillary services. During interview on 4/8/24 at 5:17 p.m., R87 stated he was very sad due to his wife's passing and denied being offered any psych or grief support R87 stated it would be helpful to talk to someone about his feelings. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/10/24 at 9:18 a.m., registered nurse (RN)-G stated the health unit coordinator (HUC) would place a referral to psych when ordered and that psych was in the facility regularly. RN-G stated if a referral was placed, the resident would typically see psych within a week or so unless it was an urgent need. RN-G further stated being aware that R87 had issues with the death of his wife and could be very sad at times. RN-G was not aware if R87 saw psych and stated that any notes would be documented int eh EHR (electronic health record). During interview on 4/10/24 at 9:36 a.m., HUC stated the social worker (SW) would typically make the psych referrals based on nursing communication, provider order, or assessments. During interview on 4/10/24 at 10:47 a.m., SW-A stated social services conducted assessments and would refer residents to psych as needed. SW-A stated she thought she offered psych to R87 in February of this year, per her PN. SW-A stated per the note R87 was already receiving psych services. SW-A referred to R87's EHR and stated there were two documents listed under the psych consult category and that was what she referred to back in February. SW-A opened the two documents in the EHR and verified the two documents were not psych notes and stated they must have been filed incorrectly. SW-A further stated she must have done the same thing back in February and assumed R87 was receiving psych services by only viewing the listed documents under psych consult and not by opening the documents to confirm. SW-A stated R87 should have had a psych referral, and all offers and refusals should be documented. During interview on 4/10/24 at 12:47 p.m., SW-B stated she reviewed interdisciplinary team meeting (IDT) minutes and could not find any evidence they discussed R87's need for psych referral. During interview on 4/10/24 at 1:30 p.m., RN-C stated if there was a referral to psych, SW would discuss with resident and obtain consent. RN-C stated R87 was appropriate for psych services and that all offers and refusals should be document. During interview on 4/10/24 at 1:44 p.m., director of nursing (DON) stated expectation was that residents would be referred to psych services as needed and that any refusals should be documented. Facility policy Ancillary Services dated 2/12/24, indicated, Ancillary services are reviewed with each care conference and updated when requested by the resident/resident representative. The policy further identified, The Social service staff or designee will document the resident's plans for ancillary health care services in the resident's [CCS] form.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 46885 Based on interview and document review the facility failed to ensure the Quality Assurance Process Improvement (QAPI) committee was effective in maintaining appropriate action plans to correct a quality deficiency identified during a previous survey related to self administration of medications (SAM) which resulted in a deficiency identified during this survey. Findings include: Review of the CASPER dated 3/28/24, indicated the facility was cited for F755 related to a resident not monitored for medication administration on the survey which exited on 3/2/23. See F554, Based on observation, interview, and document review, the facility failed to ensure a self administration of medications (SAM) assessment was completed to allow residents to safely administer their own medications for 3 of 3 (R66. R6, and R73) residents observed with medications at bedside. Quarter One 2023, QAPI minutes dated 1/1/23, through 3/31/23, were reviewed and indicated under the heading, Survey Results and Audits F755 unattended medication, education was completed, a whole house sweep was completed to check for medications in rooms, medication administration audits indicated 5/7 at 71%. Under the heading, Staff Development dated 3/1/23, indicated review medication policy with all nurses and trained medication aides (TMAs). During state survey found oxycodone in resident's room and during interview was saving the medication to mail to his wife. The minutes indicated the next meeting held would be on 7/20/23. Quarter two 2023, QAPI minutes dated 4/1/23, through 6/30/23, indicated under the heading, Survey Results and Audits medication administration audits will continue and reevaluate next quarter, second floor was 4/4 for 100%. The minutes indicated the next meeting held would be on 10/12/23. Quarter three 2023 QAPI minutes dated 7/1/23, through 9/30/23, indicated under the heading, Survey Results and Audits survey result audits completed, however had discussed last meeting to continue grooming and hygiene audits. This quarter we have 44/51 for 86%, goal is to be above 96% before discontinuing. Repositioning audits would be continued until the percentage positive was 96%. The minutes lacked notes related to medication administration audit results. The minutes indicated the next meeting would be on 1/11/24. Quarter four 2023 QAPI minutes dated 10/1/23, through 12/31/23, indicated under the heading, Survey Results and Audits indicated information on fall audits and grooming. The minutes lacked information related to medication administration. The minutes indicated the next quarterly meeting would be held 4/11/24. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on 4/11/24 at 11:36 a.m., the administrator stated QAPI meetings were held quarterly and would be transitioning to once monthly. The administrator stated performance improvement projects (PIPs) the facility was working on since last year included: management of pressure ulcers, remaining free of F tags for sexual abuse allegations, improve quality of life through STREAM, and remain in compliance with infection control. The administrator stated at quarterly meetings, they went thru the quality assurance (QA) reports, pharmacy reports, the director of nursing reports, infection control reports and then the rest of the departments, social services, nutritional services, staff development, therapeutic recreation PIP (performance improvement projects) updates, medical director updates and administrator updates. The administrator further stated they look at trends seen through the quarterly reports to see what areas have the largest growth needs. Further if negative trends were noticed, a plan would be developed through the agenda and minutes. Monitoring was usually documented in the discussion in the QAPI minutes and gave the example grooming was not where they needed to be compliance wise and if a trend was noticed they continued or began audits to get back in compliance and would check with the director of nursing regarding monitoring residents for self administration of medications. At 12:12 p.m., the administrator stated they did not continue audits from quarter three and quarter four and did not know if the monitoring was placed in the minutes, but could not locate the information in the notes. An email sent on 4/11/24 at 12:22 p.m., indicated the QAPI goals for the facility included: management of pressure ulcers, remain free of F tags in vulnerable adult and sexual abuse allegations, improve resident quality of life through STREAM and Move Forward, remain in compliance with infection control by following CMS and State guidelines, resident satisfaction with food enjoyment. An email sent on 4/11/24 at 12:30 p.m., indicated the administrator stated after talking with the director of nursing, it was documented in quarter three the survey result audits were completed including medication administration, and would continue grooming and hygiene audits. The administrator included the passage that indicated, Survey Results and Audits: Survey result audits completed, however had discussed last meeting to continue grooming and hygiene audits. This quarter we have 44/51 for 86%, goal is to be above 96% before discontinuing. A policy, Quality Assessment and Assurance (QA&A) Committee, dated 8/22/22, indicated the facility would establish and maintain a QA&A committee that oversaw the development, implementation and evaluation of the QAPI program. The committee was responsible to review minutes from the previous meetings to ensure action steps were completed and or added to the next meeting minutes. The primary goals of the QA&A committee were to establish, maintain and oversee facility systems and processes to support the delivery of quality of care and services and develop implement plans to correct quality deficiencies, routinely review and analyze data, coordinate the development, implementation, monitoring, and evaluation of performance improvement projects to achieve specific goals. Committee meeting agendas would include a review of pharmacy reports, drug regimen reviews, grievances, review of survey deficiencies, investigation deficiencies. Minutes shall be maintained in standard minute format and include the date the committee met, names of committee members present and absent, a summary of the quality of care/life areas discussed, reports and findings; a recorded summary of any approaches and action plans to be implemented, conclusions and recommendations from the committee.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42580 Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene was completed during medication administration for 2 of 4 residents (R41, R48). The facility also failed to ensure proper hand hygiene was implemented during suprapubic (S/P) catheter cares for 1 of 4 residents (R2), and during the provision of personal cares for 1 of 4 residents (R88) reviewed for infection control. Additionally, the facility failed to ensure proper personal protective equipment (PPE) was utilized for 1 of 1 resident (R266) reviewed for enhanced barrier precautions. Findings Include: Medication Administration R41's quarterly Minimum Data Set (MDS) dated [DATE], indicated R41 was cognitively intact. R41's face sheet diagnosis included other sites of candidiasis, urinary tract infection. R48's quarterly MDS dated [DATE], indicated R48 was cognitively intact, and medications included antipsychotics and anticoagulants. R48's care plan updated 4/8/2024, indicated R48 required enhanced barrier precautions related to catheter use. During observation on medication pass observation on 4/9/24 at 12:34 p.m., to 12:40 p.m., licensed practical nurse (LPN)-A opened locked medication cart and removed R41's Tylenol 500 milligrams (MG), 2 tablets, and placed in medication cup and then crushed the medication and placed in applesauce. LPN-A then gave R41 her medication in the dining room and administered the Tylenol. LPN-A then went back to the medication without sanitizing hands and removed R48's baclofen 10 mg half tab from the medication card, locked cart then took R48's medication to R48's room and administered to him. R48's EBP signage and personal protective equipment supplies were near R48's door. LPN-A then went to cart touched bottom of medication cups stacked on top of medication cart and did not perform hand hygiene. LPN-A then grabbed dressing from treatment cart for R2's S/P dressing change and went into R2's room. During interview on 4/11/24 at 9:00 a.m., LPN-A stated they should have hand sanitized between medication administration between residents but did not during medication pass observation. During interview on 4/11/24 at 9:32 p.m., director of nursing (DON) stated staff were expected to hand sanitize during medication administration between residents to prevent spread of infection. Suprapubic Catheter R2's quarterly MDS 2/22/24, indicated R2 had an indwelling catheter. (continued on next page)

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	245520	A. Building B. Wing	04/11/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2's face sheet printed 4/11/24, indicated diagnosis included Seborrheic dermatitis (a common skin condition that mainly affects your scalp. It causes scaly patches, inflamed skin and stubborn dandruff), unspecified, and obstructive and reflux uropathy (A disorder characterized by blockage of the normal flow of contents of the urinary tract). R2's care plan dated 4/8/24, indicated R2 required enhanced barrier precautions (EBP) related to catheter use. R2's physician orders dated 10/10/23, indicated S/P site dressing change once a day. During observation on 4/9/24 at 12:40 p.m., R2's EBP signage and supplies were near his door. LPN-A washed hands, donned gown, mask and gloves and removed old dressing to R2's S/P catheter site. LPN-A did not change glove, then cleaned S/P site with gauze and wound cleanser. LPN-A then applied new dressing and taped to resident S/P site after dating. LPN then removed gloves and doffed personal protective equipment. Then washed hands. During interview on 4/11/24 at 9:00 a.m., LPN-A stated they should have hand sanitized between removing dirty dressing and cleaning S/P catheter site to prevent infection to site. During interview on 4/11/24 at 9:32 p.m., DON stated staff were expected to change gloves when after removing old dressing, hand sanitize, don gloves before applying new dressing for R2 to prevent infection to S/P catheter site. Activity of Daily Living R88's MDS dated [DATE], lacked a brief interview for mental status score for cognition. R88 was dependent on staff for all cares and had a feeding tube in place. R88's face sheet printed on 4/11/24, indicated gastrostomy-feeding with flushes and acute respiratory disease-resolved. R88's care plan updated 4/8/24, indicated R88's was on enhanced barrier precautions (EBP) related to gastrostomy tube. R2 required assistance with activities of daily living. During observation on 4/10/24 at 11:01 a.m., R88 EBP signage and supplies were near R88's door. Nursing assistant (NA)-G and NA-H entered R88's room after donning gown, and gloves. NA-G removed gown and then washed R88's face and chest area while keeping privacy and dried off areas and placed blouse onto R88. NA-G then provided peri cares to frontal area then NA-H assisted to turn R88 onto side. NA-G then cleaned R88's buttock area with noted small bowel movement. NA-G used wipes and completed peri cares. NA-G did not change their gloves then grabbed R88's clean briefs and placed under buttock and turned R88 onto back to fasten. NA-G also applied clean draw sheet and placed under R88 with same unchanged glove, touching R88's clothing and linens. NA-G grabbed a hair brush then brushed R88's hair then changed gloves. NA-G sanitized hands after doffing gown and gloves. During interview on 4/10/24 at 11:46 a.m., NA-G stated they realized after observation of R88's morning cares they had not changed gloves but should have changed gloves to prevent the spread of infection. NA-G further stated was a bit nervous during observation by surveyor but was aware of infection control practices with glove changes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 4/11/24 at 9:32 p.m., DON stated staff were expected to change gloves when providing resident cares and came in contact with bowel movements to prevent the spread of infection. The facility Hand Hygiene Infection Control policy updated 1/11/2024, It is the policy of Cassia that handwashing/alcohol-based hand sanitizer be regarded as the single most important means of preventing the spread of microorganisms/transmission of infection. Hands must be washed with soap and water if visibly soiled, before eating or drinking and before and after using the bathroom. Hands must be washed with soap and water when working with residents with C-Difficile or Norovirus during an outbreak. For a single resident with C-Difficile handwashing is preferred, but alcohol-based hand sanitizer is allowed unless hands are visibly soiled, contact with bodily fluids has occurred, or in an outbreak situation. Other than the above listed situations, hand washing and hand sanitizing with an alcohol-based hand sanitizer (ABHS) agent may be used interchangeably. 46885 R266's face sheet indicated R266 admitted to the facility 4/3/24, and had the following diagnoses: multiple sclerosis severe with spasticity, dementia, type one diabetes mellitus, pressure ulcer of the right heel, retention of urine, encounter for fitting and adjustment of urinary device, encounter for change or removal of a nonsurgical wound dressing. R266's admission Minimum Data Set (MDS) was in progress. R266's physician orders dated 4/3/24, indicated R266 had a Foley catheter, monitor urine output every shift; days, evenings, and nights. R266's physician orders dated 4/5/24 indicated: bilateral buttock wounds, clean exposed wound bed with Vashe moist gauze. Do not scrub off Triad paste or use washcloth to remove. May need to let Vashe gauze soak for 5-10 minutes. Apply Triad paste onto sacral wound, dime thickness. Please only apply to the open wound, do not use as a barrier cream to the entire buttocks area. Special instructions: apply 3 times daily and with incontinence cares. Do not cover Triad paste with mepilex foam dressing. Please use Calazime for barrier cream to buttocks, perineum, surrounding intact skin areas three times a day. R266's physician orders dated 4/10/24, indicated: right heel wound care; cleanse with Vashe, pat dry, cover with mepilex and prevalon boots once a day every other day. R266's physician orders dated 4/10/24, indicated: upper and thoracic back wounds and left ankle lateral wound, remove old dressing, then soak wounds with Vashe mist for 2-5 minutes including the periwound skin. Pat gently dry. Gently apply barrier film cavilon no sting. Allow to dry. Apply mepilex, change every other day and as needed if soiled once a day every other day. R266's care plan dated 4/8/24 at 6:43 p.m., indicated R266 required enhanced barrier precautions (EBP) related to an indwelling catheter and chronic wounds. Interventions included following EBP per policy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R266's care plan dated 4/5/24, indicated R266 required extensive assist for bathing, bed mobility, dressing, grooming, oral cares, and required total assist for toileting needs and was incontinent of bowel and had a Foley catheter. R266's care sheet undated, indicated R266 required extensive assist of two for activities of daily living (ADLs), was incontinent of bowel, check and change every three to four hours, Foley catheter empty and cares every shift. The care sheet lacked information R266 was on enhanced barrier precautions. R266's nursing progress note dated 4/9/24 at 11:56 a.m., indicated teaching was provided on EBP to R266 and family member. During observation on 4/8/24 at 3:32 p.m., R266 was in her room and her urinary catheter was uncovered facing towards the window. There was no signage located on the door to indicate R266 was on enhanced barrier precautions and there was no cart outside the door with PPE. During observation on 4/8/24 at 5:06 p.m., R266's door contained signage indicated R266 was on EBP, and a cart with gowns and gloves was located down the hallway. During interview and observation on 4/10/24 between 7:40 a.m., and 7:54 a.m., nursing assistant (NA)-F entered R266's room and did not donn gloves or a gown. A sign was located on R266's door that indicated R266 was on EBP. At 7:44 a.m., NA-F was assisting R266 in positioning and did not have a gown on. R266's catheter bag was empty. At 7:46 a.m., NA-F put R266's blanket in a plastic bag and doffed gloves. At 7:50 a.m., NA-F stated she just emptied R266's catheter and had EBP training and stated prior to entering a room with a resident on EBP, gloves, gowns and a mask should be donned and further stated she did not put on a gown because the cart was not located right outside the door. NA-F verified there was a sign on R266's door. At 7:54 a.m., NA-F asked registered nurse (RN)-D if the cart down the hallway was for R266 and RN-D stated she thought it was for R266 or for another resident. During interview on 4/10/24 at 7:54 a.m., RN-D stated staff needed to donn gowns and PPE prior to going in R266's room for cares and stated R266 had a pressure injury and also had a Foley catheter and stated if you empty the catheter, gowns, goggles, mask, and gloves should be donned. RN-D stated there were two residents down the hallway on EBP and expected NA-F to wear a gown. During observation on 4/10/24 at 8:02 a.m., R266's signage on the door indicated the following, families and visitors please follow instructions for EBP, everyone must clean their hands before entering the room and when leaving the room. Providers and staff please see reverse side for additional precautions required for this room. Providers and staff wear gloves and a gown for the following high contact resident care activities: dressing, bathing, showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, central line urinary catheter, feeding tube tracheostomy ventilator wound care any skin opening requiring a dressing. Put on hand hygiene, gown, mask, gloves. The cart with gowns, gloves and hand sanitizer was located 1 door down the hall and on the opposite side of the hallway as R266's room. (continued on next page)

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