Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 18, 2025

Administrator
Redeemer Residence Inc
625 West 31st Street
Minneapolis, MN 55408

RE: CCN: 245520
Cycle Start Date: June 5, 2025

Dear Administrator:

On June 5, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Stefanie Salberg, Regional Operations Supervisor
Metro B District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by September 5, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 5, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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 _____	C 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET MINNEAPOLIS, MN 55408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 6/2/25 - 6/5/25 , a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 6/2/25-6/5/25, a standard recertification survey was conducted at your facility. In addition, multiple complaint investigations were also conducted. Your facility was found not compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiency issued: H55205728C (MN00107951) H55205509C (MN00113215) H55205734C (MN00113067) H55205729C (MN00110148) H55205733C (MN00111101) H55205731C (MN00109474) H55205730C (MN00112200) H55205732C (MN00112433) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required	F 000		

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

Electronically Signed | 06/26/2025

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

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F 000	Continued From page 1 at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative.	F 553		7/22/25

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F 553	Continued From page 2 (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident and resident guardian's participation in the development of interventions for 1 of 1 resident (R44) reviewed for participation in care planning. Findings include: According to the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated October 2023, the RAI is used to, "assist staff with evaluating goal achievement and revising care plans accordingly by enabling the nurse home to track changes in the resident's status". The RAI, "establishes a course of action with input from the resident (resident's family and/or guardian or other legally authorized representative(, resident's physician and interdisciplinary team that moves a resident toward resident-specific goals utilizing individual resident strengths and interdisciplinary expertise". The Assessment Reference Date (ARD) refers to the specific endpoint for the observation period in the MDS assessment process and is federally mandated to be completed on admission, quarterly (every 92 days), annually, with a significant change in status (SCSA), and on discharge. R44's quarterly Minimum Data Set (MDS) dated 3/18/25, identified R44 with severely impaired cognition, was dependent on staff for toileting, lower body dressing, personal hygiene and	F 553	F553 Plan of Correction It is the policy of Cassia to comply with the regulation cited under F553, which ensures resident and resident guardian's participation in the development of interventions for care planning. To assure continued compliance, the following plan has been put into place: • The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: o Resident R44 and their guardian will be immediately involved in a care planning meeting to discuss and develop appropriate interventions tailored to the resident's needs. • Actions taken to identify other potential residents having similar occurrences: o A review of all current residents' care plans will be conducted to ensure that each resident and their guardian, if applicable, have been involved in the development of their care interventions. • Measures put in place to ensure deficient practice does not recur: o Staff will receive re education on the importance of involving residents and their guardians in care planning. • Effective implementation of actions will be monitored by: o The facility will audit a random sample of resident charts weekly for three months	

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F 553	Continued From page 3 needed supervision with showering. In addition, R44's diagnoses included traumatic brain injury, diabetes, aphasia (communication disorder affecting ability to express and understand language), dementia, seizures, depression, bipolar disorder (extreme mood swings) and psychotic disorder (abnormal thinking and perception). R44's face sheet identified family member (FM)-A as emergency contact, guardian, and primary financial contact. Review of R44's MDS assessments were documented for the quarterly on 3/18/25, and 12/31/24 for annual. Review of R44's electronic medical record (EMR) in the "Observation" tab, identified one care conference was completed and documented in 2025. The date of last care conference was 1/29/25. Phone calls to FM-A were attempted with no response. During interview with director of nursing (DON) on 6/4/25 at 12:19 p.m., DON stated care conferences "should be" completed with MDS assessments. DON reviewed R44's EMR and stated the March 2025 care conference was not done. DON stated expectation of all care conference summaries to be documented and located in the "Observation" tab of EMR. DON stated the facility's social worker (SS) was responsible for scheduling and documenting the care conference note and downloading it into the EMR. DON stated he did not know why the March 2025 care conference was not done.	F 553	to ensure resident and guardian participation in care planning. Results of these audits will be reviewed by the facility QAPI committee, and they will make the decision if further monitoring/audits are recommended. • The person responsible to maintain compliance is: o Administrator or designee • Completion date: o 07/22/2025	

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F 553	Continued From page 4 During interview with SS on 6/4/25 at 1:28 p.m., SS stated the social services department was responsible for scheduling the care conferences with residents, their family, and all primary departments such as nursing, therapy, dietary, and social services to review any changes or updates on resident progress and goals of care. SS stated the care conferences were to be scheduled during the same time as the MDS assessments including admission, quarterly, significant change in status, and discharge. SS reviewed R44's EMR and stated March 2025 care conference was not done and should have been, stating, "my best guess is that we attempted to call [FM-A] but did not follow up". Facility policy titled Care Conferences and documentation of risk areas reviewed 4/11/2025 identified expectation of care conferences to be held "quarterly and with significant change in status thereafter" for long term care residents. In addition, the responsibility of coordinating and scheduling care conferences was the social services department.	F 553		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a	F 580		7/22/25

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F 580	Continued From page 5 deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by:	F 580		

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F 580	Continued From page 6 Based on interview and document review, the facility failed to ensure the physician was notified of a change in condition for 1 of 1 resident (R32) reviewed for a change of condition. Findings include: R32's admission Minimum Data Set (MDS) dated 4/29/25, indicated R32 had intact cognition. R32's provider note dated 4/18/25, indicated R32 had a history of a deep vein thrombosis (blood clot, DVT) and a pulmonary embolism (blood clot in the lungs, PE) and remained on Apixaban (blood thinner) twice daily. R32 also had a history of a stroke requiring hospitalization from 12/26/24 to 1/2/25, diabetes, schizoaffective disorder, and cancer. R32's progress note dated 5/29/25 at 7:12 p.m., indicated R32 had an "unresponsive episode" where the nursing assistant (NA) observed R32 "leaning to his left side" so licensed practical nurse (LPN)-B was notified. The progress note indicated that LPN-B completed an assessment of R32. The note indicated R32's eyes remained open during the period, and a few seconds into the assessment, R32 was able to answer questions, follow LPN-B's fingertip with eyes, pupils were equal and reactive, hand grasp was strong and reactive, and R32 denied having a headache. R32's medical record was reviewed and did not indicate the provider had been notified of R32's unresponsive episode. R32's care plan dated 4/29/25 was reviewed and did not include a history of unresponsive episodes.	F 580	Plan of Correction for Deficiency F580 It is the policy of Cassia to comply with the regulation cited under F580, which requires the facility to ensure the physician is notified of a change in condition. To assure continued compliance, the following plan has been put into place: • The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: o The physician for resident R32 has been assessed and physician has been updated on resident status. Resident remains at baseline status and no further interventions needed at this time. The resident's care plan has been updated to reflect this communication. • Actions taken to identify other potential residents having similar occurrences: o A review of all current residents' records has been conducted to identify any other instances where a physician was not notified of a change in condition. Any identified cases have been addressed promptly. • Measures put in place to ensure deficient practice does not recur: o Staff will receive re education on facility policy regarding physician notification in changes in a resident's condition. • Effective implementation of actions will be monitored by: o The facility will audit random sample of 5 resident charts weekly for three months to ensure physicians are notified of any changes in condition. Results of	

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F 580	Continued From page 7 During an interview on 6/4/25 at 10:37 a.m., registered nurse (RN)-C confirmed he was the nurse in charge of R32's care for the shift. RN-C stated he had been aware of R32 having previous episodes of hypoglycemia, but after reviewing R32's progress note referenced above, stated he "hadn't heard of [R32 having] anything like this [unresponsive episode] before". RN-C stated he would have expected the nurse to contact the provider if R32 had an unresponsive episode and would expect this to be documented in the progress notes as this was the facility procedure. RN-C confirmed he had reviewed R32's medical record and did not see that the provider had been notified. RN-C stated he would contact the provider as he felt the issue was "urgent" and "concerning". During an interview on 6/4/25 at 10:55 a.m., nurse practitioner (NP)-A stated she was not notified of R32's unresponsive episode. NP-A stated she expected the nursing staff to be "her eyes and ears" and would have expected the nursing staff to notify her of R32's unresponsive episode. NP-A stated she would have ordered additional monitoring of R32 and diagnostic testing to determine the cause of the incident. A call was made to LPN-B on 6/4/25 at 11:13 a.m., with a message left, and no return call was received. During an interview on 6/5/25 at 8:14 a.m., the unit nurse manager, RN-D, stated although she appreciated the assessment LPN-B had completed regarding R32's unresponsive episode, she would have expected LPN-B to contact the provider in case further recommendations were needed.	F 580	these audits will be reviewed by the facility QAPI committee, which will decide if further monitoring/audits are recommended. • The person responsible to maintain compliance is: o Director of Nursing and/or designee • Completion date: o 07/22/2025	

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F 580	Continued From page 8 The facility's Notification of Physician and Resident Representative dated 3/10/25, indicated the facility expected the primary provider to be updated when the resident had a change of condition as soon as possible and this should be documented in the progress notes. The policy indicated the facility would expect the staff member to contact the provider if a significant change occurred in the resident's physical, mental, or psychosocial status, if there was a need to alter treatment significantly, or if the resident needed to begin a new form of treatment.	F 580		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each	F 641		7/22/25

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REDEEMER RESIDENCE INC	625 WEST 31ST STREET MINNEAPOLIS, MN 55408

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F 641	Continued From page 9 assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded with received medications to promote continuity of care and ensure accurate care planning for 2 of 2 residents (R122 and R311) reviewed for MDS accuracy. Findings include: R122 admission MDS, dated 5/5/25, indicated R122 was admitted to the care facility on 5/1/25. Section "N" of the MDS, used to indicated what, if any, high risk medications a resident received in the past seven days, indicated R122 has received insulin injections one time in the past seven days. R122's Physician Order Report, dated 5/1/25 - 6/4/25, lacked evidence R122 was on an insulin injection. The report did indicate R122 received an Ozempic injection once a week on Sundays for a diagnosis of Diabetes Mellitus Type II. However, according to the Resident Assessment Instrument (RAI) Manual for Long-Term Care, Ozempic should not be classified as an insulin injection or a high-risk hypoglycemic medication. Ozempic's classification aligns with its pharmacological profile as a GLP-1 receptor agonist with a lower risk of hypoglycemia. During an interview on 6/3/25 at 1:20 p.m., MDS	F 641	F641 Plan of Correction It is the policy of Cassia to comply with the regulation cited under F641, ensuring the Minimum Data Set (MDS) is accurately coded with received medications to promote continuity of care and ensure accurate care planning. _____ To assure continued compliance, the following plan has been put into place: • The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: o For residents R122 and R311, the MDS will be reviewed and corrected to accurately reflect all received medications. The care plans will be updated accordingly to ensure continuity of care. • Actions taken to identify other potential residents having similar occurrences: o A comprehensive review of all current residents' MDS records will be conducted to identify any discrepancies in medication coding. Any inaccuracies found will be corrected immediately. • Measures put in place to ensure deficient practice does not recur:	

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F 641	Continued From page 10 coordinator-A stated the staff who coded R122's MDS no longer worked at the facility, and she would be unsure how to code Ozempic. MDS Coordinator-A stated she would have to refer to the RAI Manual or reach out for support from corporate. MDS Coordinator-A confirmed R122 was not receiving an insulin injection. R311's admission MDS, dated 4/14/25, indicated R311 was admitted to the care facility on 4/9/25. Section "N" of the MDS indicated R311 had received an antiplatelet and an anticoagulant medication in the past seven days. R311's Physician Order Report, dated 4/1/25 - 6/4/25, lacked evidence R311 was on an anticoagulant medication. The report did indicate R311 was on aspirin 325mg daily. However, according to the RAI Manual, aspirin should be coded as an antiplatelet medication, not an anticoagulant. During an interview on 6/3/25 at 1:28 p.m., MDS Coordinator-B confirmed R311 was not on an anticoagulant medication. MDS Coordinator-B stated Aspirin should be coded as an antiplatelet, not an anticoagulant, stating "I think it is an error." During an interview on 6/4/25 at 10:38 a.m., the director of nursing (DON) agreed section "N" of R122's and R311's MDS were coded inaccurately. A facility policy on MDS was requested and not received.	F 641	o Staff responsible for MDS coding will receive additional training on accurate documentation of medications. • Effective implementation of actions will be monitored by: o The MDS Coordinator will audit random sampling of resident charts weekly for three months to ensure accurate medication coding in the MDS. Results of these audits will be reviewed by the facility QAPI committee, which will decide if further monitoring/audits are recommended. • The person responsible to maintain compliance is: o MDS coordinator or Director of Nursing • Completion date: o 07/22/2025	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3)	F 645		7/22/25

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F 645	Continued From page 11 §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was	F 645		

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F 645	Continued From page 12 transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a Level I Pre-Admission Screening (PAS) and, if needed, a Level II Pre-admission Screening and Resident Review (PASARR) was completed to screen for mental health needs for 2 of 3 residents (R6, R32) reviewed for PAS. Findings include: R6's admission Minimum Data Set (MDS) dated	F 645	F645 Plan of Correction It is the policy of Cassia to comply with the requirement to ensure a Level I Pre-Admission Screening (PAS) and, if needed, a Level II Pre-admission Screening and Resident Review (PASARR) is completed to screen for mental health needs. To assure continued compliance, the following plan has been put into place: " The following corrective action will be	

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F 645	Continued From page 13 5/23/25, indicated R6 had intact cognition. R6's medical diagnoses list dated 5/20/25, indicated R6 was diagnosed with schizoaffective disorder with auditory hallucinations. R6's PAS notice dated 5/19/25, indicated a copy of the PAS was included with this notice but the PAS was not final until the lead agency sent a final determination to the nursing home. R6's entire medical record was reviewed and lacked evidence a final determination had been received. R32's admission MDS dated 4/29/25, indicated R32 had intact cognition. R32's medical diagnoses list dated 4/25/25, indicated R32 was diagnosed with schizoaffective disorder with an "acute exacerbation". R32's PAS notice dated 5/7/25, indicated a copy of the PAS was included with this notice but the PAS was not final until the lead agency sent a final determination to the nursing home. R32's entire medical record was reviewed and lacked evidence a final determination had been received. During an interview on 6/4/25 at 2:21 p.m., the director of nursing (DON) confirmed he had reviewed R6's and R32's medical records and could not find the final PASARR determination for either resident. The DON stated they used to get the final PASARR faxed to them but recently the process changed and they were supposed to request the copies electronically from the lead agency and that had not been happening. The DON stated they will now work to change the process to ensure the final determination was received for each resident.	F 645	done for the resident(s) found to have been affected by the deficient practice: Immediate PAS and PASARR screenings will be conducted for residents R6 and R32 to ensure their mental health needs are appropriately assessed and addressed. " Actions taken to identify other potential residents having similar occurrences: " A review of all residents' records will be conducted to identify any other individuals who may not have received the required PAS and PASARR screenings. This will also take place for residents set to admit in the future " Measures put in place to ensure deficient practice does not recur: Staff will receive re education on facility procedures of conducting PAS and PASARR screenings. A checklist will be implemented to ensure all new admissions undergo the necessary screenings. " Effective implementation of actions will be monitored by: The facility will audit 100% of new admission charts weekly for three months to ensure PAS and PASARR screenings are completed as required. Results of these audits will be reviewed by the facility QAPI committee, and they will make the decision if further monitoring/audits are recommended. " The person responsible to maintain compliance is: Administrator or Designee " Completion date: " 07/22/2025	

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F 645	Continued From page 14 The facility's Pre-Admission Screening and Resident Review Policy dated 4/11/25, indicated copies of the PASARR approval would be uploaded in each resident's medical record.	F 645		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine oral hygiene was completed to reduce the risk of complication for 1 of 4 residents (R39) reviewed for activities of daily living (ADLs) who were dependent on staff for their care. Findings include: R39's quarterly Minimum Data Set (MDS) dated 4/16/25, indicated R39 had moderately impaired cognition and did not have rejection of care behaviors during the look-back period (LBP). The MDS indicated that R39 required substantial assistance to complete oral hygiene. R39's care plan dated 5/19/25, indicated R39 had full upper dentures, natural teeth on the bottom, with the front teeth missing. The care plan indicated staff were to provide "extensive" assistance with oral care. R39's Point of Care History dated 5/3/25 to 6/2/25 was reviewed and did not include documentation	F 677	F677 Plan of Correction It is the policy of Cassia to comply with the regulation cited under F677, ensuring routine oral hygiene is completed to reduce the risk of complications for residents dependent on staff for their care. To assure continued compliance, the following plan has been put into place: • The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: Immediate oral hygiene care was provided to Resident R39. • Actions taken to identify other potential residents having similar occurrences: A review of all residents dependent on staff for oral hygiene was conducted to identify any other residents who may have been affected. Observations and interviews were carried out to ensure all residents are receiving appropriate oral hygiene care. • Measures put in place to ensure	7/22/25

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F 677	Continued From page 15 of oral care. During an interview on 6/2/25 at 3:12 p.m., R39 stated staff were supposed to help her brush her teeth twice a day but had not been doing so. R39 stated they used to set a basin with a toothbrush on her bedside table and then leave but she was unable to complete the task by herself so now staff did not even do that much. During an interview on 6/4/25 at 11:46 a.m., nursing assistant (NA)-C confirmed she was R39's aide for the shift. NA-C stated that R39 had dentures and no real teeth. NA-C stated she had assisted R39 with putting her dentures in this morning but as R39 had no real teeth, had not brushed any. During an observation on 6/4/25 at 11:51 a.m., R39 was observed lying in bed. R39 was observed to have no upper teeth, with the front couple of bottom teeth missing with teeth remaining on both the bottom left and right side of the mouth. R39's teeth were observed yellowed with a white/yellow matter observed around the bottom edges of teeth. During an interview on 6/5/25 at 8:33 a.m., registered nurse (RN)-B, the unit nurse manager stated oral hygiene was the "standard of care" and staff needed to assist residents with completing this preferably twice a day. RN-B stated assisting the resident with oral care was important, so oral bacteria does not spread and to prevent things like gingivitis. RN-B stated, "the only place" he could think of that staff may document that oral care was completed was on the "POC" (point of care) charting.	F 677	deficient practice does not recur: Staff will be re educated on the importance of oral hygiene and proper techniques. • Effective implementation of actions will be monitored by: The Director of Nursing or Designee will audit random sampling of resident charts weekly for three months to ensure compliance with oral hygiene practices. Results of these audits will be reviewed by the facility QAPI committee, which will decide if further monitoring/audits are recommended. • The person responsible to maintain compliance is: Director of Nursing or Designee • Completion date: 07/22/2025	

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F 677	Continued From page 16 A policy regarding oral care was requested and not received.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a developed skin condition was appropriately and consistently treated to promote healing for 1 of 2 residents (R49) reviewed who had developed dry skin. Findings include: R49's annual Minimum Data Set (MDS), dated 4/30/25, identified R49 had intact cognition and demonstrated no delusional thinking. Further, the MDS recorded R49 received dialysis and had no current ulcers, wounds or other skin problems (i.e., burns, lesions). R49's care plan, revised 5/19/25, identified R49 required assistance with activities of daily living (ADLs) due to multiple medical conditions including hemiparesis. The care plan outlined R49 was at risk of altered skin integrity due to heart failure and R49 had a history of pressure ulcers. The care plan listed multiple interventions	F 684	F684 Plan of Correction It is the policy of Cassia to comply with the regulation cited under F684, which requires facilities to ensure that residents receive proper treatment and care to promote healing of skin conditions. To assure continued compliance, the following plan has been put into place: • The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: • o Resident R49 skin remains intact and in good skin condition. The resident's skin hydration cream has been re ordered from the pharmacy and resident is receiving treatment for the dry skin condition. • Actions taken to identify other potential residents having similar occurrences: • o A review of all current residents' skin	7/22/25

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F 684	Continued From page 17 to help R49's skin remain intact including, "Moisturize dry skin." On 6/2/25 at 7:09 p.m., R49 was observed lying in bed while in his room. R49 was interviewed and expressed he had dry, itchy skin on his arms and legs which he didn't feel was being treated. R49 stated staff were supposed to be applying a lotion or oil to it a few times each day; however, it wasn't being consistently done. R39 showed his arms which were visibly dry with areas of white-colored skin (i.e., flaky) present. R49's Progress Note, dated 3/20/25 and completed by the medical provider, identified R49 was seen following a hospitalization. The note included text which read, " ... on exam[,] patient skin is very dry and scaley. this [sic] is chronic almost. will [sic] benefit from a lotion for dry skin." The note listed a section labeled, "Plan," which directed, "Orders: Start cerave cream apply to skin twice a day." A corresponding View Prescription Order, printed 6/4/25, was authored by another medical provider and listed a received date, "03/20/2025." The order named the CeraVe with directions, "Apply CeraVe Cream BID [twice daily] topically head-toe for severe Dry Skin. (Okay for alternative topical cream)." On 6/4/25 at 8:09 a.m., R49 was again observed in his room, now seated in a high-back Broda-style wheelchair. R49 continued to have visible dry skin with some areas of light white-colored scaling present on his arms and hands. R49 reiterated nobody was consistently applying lotion or cream to his dry skin adding aloud, "Nope." R49 expressed, "I think I need it." R49's Medication Administration Record (MAR),	F 684	assessments will be conducted to identify residents with skin alterations for appropriate treatments to aide in healing. Physician and family members will be updated with changes to the plan of care accordingly. • Measures put in place to ensure deficient practice does not recur: • o Staff will receive re education on the importance of consistent skin care and the proper documentation of skin conditions and treatments; including the process for re ordering prescription creams. • Effective implementation of actions will be monitored by: • o The Director of Nursing or designee will audit a random sample of 5 resident charts weekly for three months to ensure proper treatment and documentation of skin conditions. Results of these audits will be reviewed by the facility QAPI committee, which will decide if further monitoring/audits are recommended. • The person responsible to maintain compliance is: • o Director of Nursing or Designee • Completion date: • o 07/22/2025	

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F 684	Continued From page 18 dated 5/2025, identified R49's order for CeraVe cream to be applied topically BID with a listed start date, "03/20/2025 - Open Ended." The MAR outlined an, "AM," and, "HS [bedtime]," time for administration along with staff initials to record the administration or refusal. This treatment was recorded as being completed the entire month during the morning (i.e., AM) shift; however, had 12 recorded days on the evening (i.e., HS) time frame of being not administered with added text, "Not Administered: Drug/Item Unavailable." R49's MAR, dated 6/2025, identified the same order for CeraVe and, again, spacing to record it's administration or refusal. This identified only three days (1/1 to 1/3) of history recorded; however, again, showed one of the six doses as not administered with added rationale, "Drug/item Unavailable." The MAR lacked evidence of what, if any, alternative cream or lotion had been applied on days when the CeraVe was not available. When interviewed on 6/4/25 at 9:04 a.m., nursing assistant (NA)-B verified they had worked with R49 prior and described him as needing "total care" from staff. NA-B stated they had noticed R49 to have dry skin and expressed aloud, "He's always had very dry skin, always." NA-B stated they sometimes applied lotion to R49's skin but not consistently, and expressed they were unsure what, if any, treatments the nurses were doing for it. Further, NA-B stated R49's dry skin condition was "the same" over the past several weeks and reiterated, "He's very dry." On 6/4/25 at 9:46 a.m., registered nurse (RN)-E was interviewed, and verified they routinely worked with R49. RN-E stated R49 was on dialysis and expressed they had noticed R49 to	F 684		

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F 684	Continued From page 19 have had "frequent dry skin." RN-E stated R49 had an order for "fancy lotion [i.e., CeraVe]" awhile prior but the insurance wouldn't cover it so, as a result, they (RN-E) had just been applying A&D ointment (a skin protectant ointment) to his skin. RN-E stated the nurse working should catch and resolve a discrepancy between the MAR and any applied topical medications or creams, and acknowledged R49's current order in the MAR still called for the CeraVe lotion to be applied. RN-E attributed the lack of clarification being obtained to, "We've been using A&D and [we're] so busy you know," adding further, "I haven't had a chance to update it [MAR]." RN-E stated they were unsure what cream or ointment the other nurses working with R49 were using and reiterated the use of A&D ointment was "what I do." Further, RN-E verified there was no current supply of CeraVe in the medication cart, and stated they felt R49's developed dry skin was "about the same" over the past weeks. R49's medical record was reviewed and lacked evidence the progress note directing CeraVe and the physician order, completed by a different provider, were clarified to ensure the correct product was being applied; nor did the record have evidence of what, if any, attempts were made to obtain the CeraVe lotion despite apparent insurance refusal to cover it. The record lacked evidence what, if any, additional interventions had been considered or developed despite R49's skin condition remaining and not improving over several weeks as observed by the direct care staff; and further, the record lacked any recorded dictation or evidence of what, if any, cream or lotion staff had been applying to R49's skin when signing off on the MAR the treatment was done despite the CeraVe not physically being	F 684		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEEMER RESIDENCE INC	625 WEST 31ST STREET MINNEAPOLIS, MN 55408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 20 present in the care center per direct care staff. On 6/4/25 at 10:59 a.m., registered nurse manager (RN)-B was interviewed, and verified they had an opportunity to review the medical record. RN-B explained the CeraVe wasn't covered by R49's insurance and expressed what "typically happens" in such a case would be the care center considering to cover the cost of it instead. RN-B stated they had just called the pharmacy and the medication (CeraVe) would be sent over that day. RN-B stated they followed-up with RN-E who confirmed they had been applying A&D ointment instead, and RN-B directed RN-E the provider should be updated and order changed. RN-B verified the ordered CeraVe was not physically present on-campus and expressed none of the nurses had updated them on it not being filled or available. RN-B stated they recalled seeing a communication from pharmacy about it not being covered but it had just been "overlooked" since then. RN-B stated it was important to ensure ordered treatments are done as they were "ordered for a reason" adding aloud, "We should follow the order." RN-B verified if a medication was not available, then the provider should be updated and order clarified or obtained adding, "You want to follow the doctor's order." RN-B stated not clarifying an order or updating the provider "could be a bigger problem" if it involved more than lotion. Later on 6/4/25 at 12:04 p.m., RN-B was interviewed and provided the physician's order which outlined use of an alternative lotion and/or cream was allowable. RN-B stated use of A&D ointment in place of CeraVe "wouldn't be my first choice" and acknowledged them to have different ingredients. RN-B reiterated nurses should be reporting creams and medications which weren't available	F 684		

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F 684	Continued From page 21 adding, "So I can check into it." RN-B verified the MAR lacked evidence of what, if any, cream or lotion had been applied to R49's skin despite the CeraVe not being available and, as a result, acknowledged there was no way to know what, if any, treatment the nurses were actually doing. RN-B stated it was important to ensure ongoing, consistent treatment for R49's dry skin was done as he was "more prone to breakdown." On 6/5/25 at 10:37 a.m., the director of nursing (DON) was interviewed. DON verified R49 had the CeraVe delivered that morning and expressed staff should be using an alternate lotion on R49's skin like a Eucerin (lotion) which were available in the medication carts. DON stated "the same" treatment should be applied amongst all the nurses, and verified if a medication is repeatedly unavailable then staff should update the nursing leadership. DON stated using the same, ongoing treatment modality would help ensure "better healing." A facility-provided Skin Integrity policy, dated 3/2025, identified a procedure which included the NA doing daily skin checks and updating the nurses with concerns. The policy continued, "Nurse will implement appropriate treatment for new skin alterations using wound care protocol or base on Provider recommendations." The policy lacked specific information or directions on how to address a skin concern which was not a pressure ulcer or wound (i.e., dry skin).	F 684		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		7/22/25

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F 880	Continued From page 22 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	F 880		

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F 880	Continued From page 23 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to follow infection control standards of practice for cleaning of hard surfaces in the resident room for 1 of 1 residents. In addition, the facility failed to ensure personal laundry was transported and delivered in a manner that prevented risk of contamination for 1 of 3 hallways (3rd floor) observed for linen transportation. In addition, the facility had failed to ensure transmission-based precautions (TBP) were assessed for and implemented timely for 1 of 1 residents (R39) reviewed with symptoms of a possible gastrointestinal illness.	F 880	F880 Plan of Correction It is the policy of Cassia to comply with infection control standards as cited in regulation F880. To assure continued compliance, the following plan has been put into place: • The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: o The resident's room was immediately cleaned and disinfected according to infection control standards. Personal laundry will be transported using appropriate contamination prevention	

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F 880	Continued From page 24 Findings include: Wheelchair arm rests: According to the Centers for Disease Control (CDC) Guidelines for Environmental Infection Control in Health-Care Facilities (2003) the cleaning and disinfection of environmental surfaces is fundamental in reducing their potential contribution to the incidence of healthcare-associated infections. R44's quarterly Minimum Data Set (MDS) dated 3/18/25 identified R44 with severely impaired cognition, was dependent on staff for toileting, lower body dressing, personal hygiene and needed supervision with showering. In addition, R44 diagnoses include traumatic brain injury, diabetes, aphasia (communication disorder affecting ability to express and understand language), dementia, seizures, depression, bipolar disorder (extreme mood swings), and psychotic disorder (abnormal thinking and perception). During observation on 6/2/25 at 2:43 p.m., R44 was laying bed with clothes on. Their wheelchair was located near foot of bed and had visibly crackled vinyl armrests with foam padding noted under the material which was pulling away. During observation and interview with nursing assistant (NA)-A on 6/4/25 at 9:15 a.m., NA-A looked at R44's wheelchair arm rests and stated, "Yes, that wheelchair is really shabby looking and broken up like cracked material. I can see the foam under the cracked material and even the metal portion of the arm rest." During observation and interview with trained	F 880	methods. Transmission-based precautions were assessed and implemented for the resident with symptoms of gastrointestinal illness. • Actions taken to identify other potential residents having similar occurrences: o Personal laundry will be transported using appropriate contamination prevention methods. Transmission based precautions will be identified and implemented appropriately. Facility will implement infection control standards of practice for cleaning of hard surfaces related to wheelchairs. • Measures put in place to ensure deficient practice does not recur: o Staff will receive re education on infection control standards, proper cleaning of hard surfaces and wheelchairs, correct procedures for laundry transportation, and timely implementation of transmission-based precautions. • Effective implementation of actions will be monitored by: o The Infection Control Nurse will audit a random sampling of resident rooms and laundry transportation processes weekly for three months to ensure compliance with infection control standards. Results of these audits will be reviewed by the facility QAPI committee, and they will make the decision if further monitoring/audits are recommended. • The persons responsible to maintain compliance is: o Infection preventionist, Environmental service director, or designee.	

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F 880	Continued From page 25 medication aide (TMA)-A on 6/4/25 at 1:22 p.m., TMA-A looked at R44's wheelchair arm rests and stated, "not a cleanable surface because it is worn out." During observation and interview with 3rd floor nurse manager (RN)-A on 6/4/25 at 1:25 p.m., RN-A looked at R44's wheelchair arm rests and stated, "[they] need to be replaced because it is rough and [sic] the edges and could harbor infection." During observation and interview with DON on 6/4/25 at 1:37 p.m., DON looked at R44's wheelchair arm rests and stated, "I agree that it is not smooth surface to clean and wipe down. Material is cracked and should be smooth" and stated it was, "a concern for infection control." During interview with facility's infection control preventionist (ICPC) on 6/4/25 at 1:55 p.m., ICPC looked at R44's wheelchair arm rests and stated, "Yes that would not be a cleanable surface at this time. Armrests should be a smooth surface. I agree it is a concern for infection control." During interview with housekeeper (HK)-B on 6/5/25 at 10:05 a.m., HK-B described expectation of housekeeping staff to wipe wheelchairs "only if I see visible dirt". HK-B stated "if material on arm rests were cracked and peeling then I would not be able to clean it correctly. [sic] could be a place for germs to grow." Linen cart: During observation on 6/4/25 at 9:10 a.m., laundry aide (LA)-A wheeled a laundry cart to 3rd floor hallway outside 3 West unit, obtained personal laundry from the cart and left the cart	F 880	• Completion date: o 07/22/2025	

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F 880	Continued From page 26 uncovered before walking away. Personal laundry was visible on the clothes hangers. At 9:11 a.m., LA-A returned to the uncovered laundry cart with empty clothes hangers in her hands and then wheeled the uncovered laundry cart past nursing station, dining room with three residents sitting in wheelchairs, and the main hallway past resident rooms. When she approached main elevators LA-A pulled the folded-up linen cover over the laundry. During interview with LA-A on 6/4/25 at 9:12 a.m., LA-A stated, "I left the [laundry] cart here uncovered and walked away. It should be covered because of [risk of] contamination and some residents could access it [unattended]". Facility policy titled Standard precaution reviewed 7/3/24, state, "Standard Precautions apply to all patients and in all situations, regardless of diagnosis or presumed infection status. Because all residents can serve as reservoirs for infectious agents, adherence to Standard Precautions during the care of ALL residents is essential to interrupting the transmission of microorganisms. Standard precautions also intend to protect residents by ensuring that healthcare personnel do not carry infectious agents to residents on their hands or via equipment used during resident care." In addition, the policy identified procedure for, "Handling and transporting of linen in a manner that avoids skin and mucous membrane exposure and avoids contamination of clothing." TBP	F 880		

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F 880	Continued From page 27	F 880		

The CDC guideline titled Summary of Recommendations, Guidelines for Isolation Precautions: Preventing transmission of Infectious Agents in Healthcare Settings dated 11/27/23, indicated in addition to standard precautions, TBP should be used with residents with "known or suspected" infection where additional precautions are needed to prevent transmission.

R39's quarterly MDS dated 4/16/25, indicated R39 had moderately impaired cognition and was diagnosed with heart failure, kidney disease, and diabetes.

R39's care plan dated 5/19/25, was reviewed and did not include a history of nausea and vomiting.

R39's progress note dated 6/3/25 at 3:10 p.m., indicated R39 had complained of nausea and vomiting after both breakfast and lunch. The progress note indicated R39 had three episodes of vomiting during shift.

During an interview and observation on 6/4/25 at 8:10 a.m., NA-C was observed to enter R39's room, complete hand hygiene, and apply gloves. R39 stated she felt "really nauseous" today and her stomach was and explains using hand waving in a circular motion. R39 then asked NA-C for her "throw-up" container. NA-C was observed to hand R39 an empty water jug. NA-C was observed to assist R39 with personal hygiene tasks such as perineal care, washing under skin clean-folds, and washing face while R39 held empty water jug close to her mouth. R39 stated she had been feeling nausea since, not last the night of 6/2/25 and was vomiting yesterday and this was abnormal for her. NA-C was observed to remove

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F 880	Continued From page 28 gloves when cares were completed and complete hand hygiene. No further personal protective equipment (PPE) such as a gown or mask observed to be used. During an interview on 6/4/25 at 8:35 p.m., the ICPC, a registered nurse, stated they were now going to start utilizing droplet precautions when caring for R39. The ICPC stated she had reviewed R39's progress notes this morning and noticed that R39 had nausea and vomiting the previous day, so she was going to implement the precautions as this could be a symptom of an infectious disease. The ICPC stated she would have expected the nurse who was care for R39 at the time the symptoms had started to implement the precautions yesterday but that had not occurred. RN-E stated she had notified the provider yesterday of R39's nausea and vomiting and the provider had ordered a clear liquid diet but had not mentioned the need for precautions, so she had not implemented any. The facility's Transmission-Based Precautions, Enhanced Barrier Precautions and Empiric Precautions policy dated 5/13/25, indicated residents with a suspected or confirmed case of a communicable disease that was spread by droplet or contact with an infection environment should be placed on TBP until the condition has been ruled out or the criteria for removal from isolation had been met.	F 880		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/03/2025. At the time of this survey, Redeemer Residence was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/26/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Redeemer Residence is a 3-story building with a full basement. The building was constructed at 3 different times. The original 3-story building was constructed in 1960 and was determined to be of Type II(222) construction. In 1975, a 3-story addition was constructed to the South that was determined to be of Type II(222) construction. In 1995, a 3-story addition was constructed to the East that was determined to be of Type II(222) construction. This facility is fully protected throughout by an automatic fire sprinkler system	K 000		

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K 000	Continued From page 2 and has a fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 119 beds and had a census of 110 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 225 SS=E	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwell enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.3, 7.2.2.5.1.1, 7.2.2.5.3, 7.1.3.2.3, and 7.1.3.2. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 06/03/2025 at 11:35 AM, it was revealed by observation that there were two penetrations into stairwell D at the bottom around a sprinkler pipe	K 225	K225 Brief description of corrective action or planned corrective action: The facility will immediately repair and reinforce all stairwell enclosures to comply with NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.3, 7.2.2.5.1.1, 7.2.2.5.3, 7.1.3.2.3, and 7.1.3.2. This includes sealing any gaps, ensuring doors close properly, and verifying that all fire-rated materials are intact. Steps to prevent recurrence: 1. Conduct a comprehensive inspection	7/22/25

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K 225	Continued From page 3 and an electrical conduit that were not sealed. 2. On 06/03/2025 at 12:23 PM, it was revealed by observation that air filters were stored at the top of the A stairwell. An interview with the Maintenance Director and the Administrator verified these deficient findings at the time of discovery.	K 225	of all stairwell enclosures monthly to identify and address any potential issues promptly. 2. Train maintenance staff on the specific requirements of NFPA 101 related to stairwell enclosures to ensure ongoing compliance. 3. Facility will Implement Above Ceiling Inspection Smoke Penetration Form for quarterly audits. How the facility plans to monitor future performance to ensure solutions are sustained: The facility will review the Above Ceiling Inspection Smoke Penetration Form to demonstrate compliance with NFPA 101 standards. Results will be reviewed in quarterly QAPI meetings to ensure continuous adherence. Person responsible for compliance: The Maintenance Supervisor will be responsible for ensuring compliance with the corrective actions and ongoing monitoring. Date of completion: 7/22/25	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1.	K 291	K291 Brief description of corrective action or planned corrective action: The facility has immediately conducted a comprehensive	7/22/25

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K 291	Continued From page 4 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/03/2025 between 09:30 AM and 01:15 PM, it was revealed by a review of available documentation that at the time of the survey, the facility could not provide documentation showing that they had tested the emergency light in the electrical room for 90 minutes within the last year. An interview with the Maintenance Director and the Administrator verified this deficient finding at the time of discovery.	K 291	test of all emergency lighting systems to ensure compliance with NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. Any identified deficiencies have been corrected to ensure all emergency lighting is fully operational. Steps to prevent recurrence: 1. Schedule regular monthly testing of emergency lighting systems and document on facility form for monthly and annual safety checks. 2. Train maintenance staff on the requirements of NFPA 101 regarding emergency lighting. How the facility plans to monitor future performance to ensure solutions are sustained: The facility will conduct quarterly audits of the emergency lighting test logs to ensure compliance with testing schedules and to verify that any issues are promptly addressed. Results of the audits will be reviewed in quarterly QAPI meetings. Person responsible for compliance: The Maintenance Supervisor is responsible for ensuring compliance with emergency lighting testing requirements. Date of completion: 7/22/25	
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system	K 345		7/22/25

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K 345	Continued From page 5 acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3, and NFPA 70, (2011 edition), National Electrical Code, sections 760.24, 760.53, and 300.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/03/2025 at 11:49 AM, it was revealed by observation that in room B07 in the basement, there was a section of fire alarm wire not in conduit between the two sprinkler valves on the sprinkler riser. An interview with the Maintenance Director and the Administrator verified this deficient finding at the time of discovery.	K 345	K345 Brief description of corrective action or planned corrective action: The facility has immediately engaged a certified fire alarm technician to inspect and repair the fire alarm system to ensure compliance with NFPA 101 (2012 edition) and NFPA 70 (2011 edition) standards. Steps to prevent recurrence: 1. Schedule quarterly inspections of the fire alarm system by a certified technician. 2. All repairs will be recorded in maintenance care per facility protocols. How the facility plans to monitor future performance to ensure solutions are sustained: The facility will review fire suppression quarterly and annually reports as provided by vendor for compliance. All results will be reviewed at quarterly QAPI meetings. Person responsible for compliance: The Maintenance Supervisor will be responsible for ensuring ongoing compliance with fire alarm system standards. Date of completion: 7/22/25	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection,	K 353		7/22/25

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K 353	Continued From page 6 Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the fire sprinkler/ standpipe system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 6.3.4.1, and 6.3.4.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 06/03/2025 at 12:08 PM, it was revealed by observation that the gauge on the standpipe at the top of the B stairwell was dated 2013 and had no documentation showing that it had been calibrated within the last five years. An interview with the Maintenance Director and the Administrator verified this deficient finding at the time of discovery.	K 353	K353 Brief description of corrective action or planned corrective action: The facility has immediately engaged a certified fire protection service to inspect and maintain the fire sprinkler/standpipe system to ensure compliance with NFPA 101 (2012 edition) and NFPA 25 (2011 edition) standards. Steps to prevent recurrence: 1. Schedule regular inspections and maintenance of the fire sprinkler/standpipe system by a certified service provider every six months. 2. Train maintenance staff to recognize and report any visible issues with the fire protection systems immediately. 3. Implement a checklist for monthly visual inspections by facility maintenance staff to identify potential issues early. How the facility plans to monitor future performance to ensure solutions are	

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K 353	Continued From page 7	K 353	sustained: • Conduct quarterly audits of inspection and maintenance records to ensure compliance with scheduled activities at the quarterly QAPI meetings. • Review monthly visual inspection checklists during monthly safety committee meetings to address any identified issues promptly. Person responsible for compliance: The Maintenance Director will be responsible for ensuring ongoing compliance with fire protection system standards. Date of completion: 7/22/25	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or	K 363		7/22/25

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K 363	Continued From page 8 pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/03/2025 at 12:47 PM, it was revealed by observation that the latch on the door to the supply room near resident room 106 was stuck, causing the door to not latch. An interview with the Maintenance Director and the Administrator verified this deficient finding at the time of discovery.	K 363	K363 Brief description of corrective action or planned corrective action: The facility has immediately repaired the corridor doors to ensure they close and latch properly, in compliance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. Steps to prevent recurrence: 1. Conduct a facility-wide audit of all corridor doors to identify any additional issues. 2. Train maintenance staff on the importance of maintaining corridor doors in compliance with NFPA standards. How the facility plans to monitor future performance to ensure solutions are sustained: • Random audits will be conducted for the next 90 days by the maintenance team to ensure all corridor doors are functioning correctly. Will continue to	

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K 363	Continued From page 9	K 363	complete annual door review per regulations. Results of the audits will be reviewed in the quarterly QAPI meetings to address any issues promptly. Person responsible for compliance: • Maintenance Supervisor Date of completion: • 7/22/25	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 06/03/2025 at 10:58 AM, it was revealed by observation that the smoke barrier near storage	K 372	K372 Brief description of corrective action or planned corrective action: The facility will immediately repair and seal all identified breaches in the smoke barriers to ensure compliance with NFPA 101 (2012 edition), Life Safety Code sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. Steps to prevent recurrence: 1. Conduct a comprehensive inspection of all smoke barriers within the facility to	7/22/25

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K 372	Continued From page 10 room 320 had a penetration above the right side of the smoke barrier doors that was not sealed. 2. On 06/03/2025 at 11:05 AM, it was revealed by observation that the smoke barrier on the third floor in the west dining room had a penetration caused by flexible conduit and sprinkler pipes that was not sealed. 3. On 06/03/2025 at 11:15 AM, it was revealed by observation that the smoke barrier on the second floor in the west dining room had a penetration caused by flexible conduit and sprinkler pipes that was not sealed. 4. On 06/03/2025 at 11:20 AM, it was revealed by observation that the smoke barrier near resident room 235 was not sealed above the smoke barrier doors around beams and a section of missing drywall. 5. On 06/03/2025 at 11:25 AM, it was revealed by observation that the smoke barrier on the first floor near stairwell D was not sealed above the smoke barrier doors around a beam. 6. On 06/03/2025 at 11:32 AM, it was revealed by observation that the smoke barrier was not sealed around wiring on the first floor above the lower level/ kitchen dining room doors. An interview with the Maintenance Director and the Administrator verified these deficient findings at the time of discovery.	K 372	identify any additional breaches or areas of concern. 2. Implement a routine maintenance schedule to regularly inspect and maintain smoke barriers. 3. Train maintenance staff on the importance of maintaining smoke barriers and recognizing potential issues. How the facility plans to monitor future performance to ensure solutions are sustained: The facility will perform quarterly audits of smoke barriers to ensure they remain intact and compliant. Results will be reviewed in quarterly QAPI meetings to address any issues promptly. Person responsible for compliance: The Maintenance Director will be responsible for ensuring compliance with smoke barrier maintenance and monitoring. Date of completion: 7/22/25	
K 541 SS=E	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry	K 541		7/22/25

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K 541	Continued From page 11 Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain laundry chutes per NFPA 101 (2012 edition), Life Safety Code, section 19.5.4.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 06/03/2025 at 12:11 PM, it was revealed by observation that the door on the third-floor laundry chute did not latch when testing the self-closing device.	K 541	K541 Brief description of corrective action or planned corrective action: The facility has immediately repaired and secured the laundry chute doors to ensure they are self-closing and latching as required by NFPA 101 (2012 edition), Life Safety Code, section 19.5.4.1. Steps to prevent recurrence: 1. Conduct weekly inspections for 90 days of all laundry chute doors to ensure they remain in proper working order. 2. Train maintenance staff on the importance of maintaining laundry chutes	

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K 541	Continued From page 12 An interview with the Maintenance Director and the Administrator verified this deficient finding at the time of discovery.	K 541	according to NFPA standards. How the facility plans to monitor future performance to ensure solutions are sustained: The facility will incorporate the laundry chute inspection into the monthly safety audit, Results will be reviewed by the safety committee to ensure ongoing compliance. Person responsible for compliance: The Maintenance Supervisor will be responsible for ensuring compliance with the laundry chute maintenance requirements. Date of completion: 7/22/25	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of	K 920		7/22/25

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K 920	Continued From page 13 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 06/03/2025 at 12:57 PM, it was revealed by observation that there were two power strips daisy-chained together in the Admissions Office. 2. On 06/03/2025 at 12:59 PM, it was revealed by observation that there were two power strips daisy-chained together in the Social Services Office. An interview with the Maintenance Director and the Administrator verified these deficient findings at the time of discovery.	K 920	K920 Brief description of corrective action or planned corrective action: The facility immediately removed all non-compliant electrical adaptive devices identified during the survey. Replacement devices that meet NFPA 99, NFPA 101, NFPA 70, and UL 1363 standards were installed to ensure compliance. _____ Steps to prevent recurrence: 1. Conduct a comprehensive audit of all electrical adaptive devices within the facility to ensure compliance with relevant codes and standards. 2. Train maintenance staff on the identification and proper usage of compliant electrical devices. 3. All adaptive devices will be noted in our annual outlet inspection for proper usage. _____ How the facility plans to monitor future performance to ensure solutions are sustained: The facility will perform random audits for the next 90 days of electrical devices and document findings. Any non-compliance will be addressed immediately. Results will be reviewed in quarterly QAPI meetings to ensure ongoing compliance and address any emerging issues.	

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K 920	Continued From page 14	K 920	_____ Person responsible for compliance: The Maintenance Supervisor will be responsible for ensuring compliance with electrical device standards and maintaining documentation of audits and corrective actions. _____ Date of completion: 7/22/25	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room,	K 923		7/22/25

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REDEEMER RESIDENCE INC	**625 WEST 31ST STREET** **MINNEAPOLIS, MN 55408**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 15 where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain oxygen storage per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2.6 and 11.6.2.3 (11). This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/03/2025 at 12:13 PM, it was revealed by observation that there were two oxygen cylinders not secured in stands or carts in oxygen room 345. An interview with the Maintenance Director and the Administrator verified this deficient finding at the time of discovery.	K 923	K923 Brief description of corrective action or planned corrective action: The facility immediately reorganized the oxygen storage area to comply with NFPA 99 (2012 edition) standards, ensuring all oxygen cylinders are stored securely and appropriately. Steps to prevent recurrence: 1. Conducted a training session for all relevant staff on proper oxygen storage procedures as per NFPA 99 standards. 2. Implemented a daily checklist for staff to verify the correct storage of oxygen cylinders. 3. Assigned a dedicated staff member to oversee the oxygen storage area during each shift. How the facility plans to monitor future performance to ensure solutions are sustained: • The facility will perform weekly audits of the oxygen storage area to ensure ongoing compliance with NFPA 99 standards.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING **01 - BUILDING 01** B. WING _____	**06/03/2025**

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K 923	Continued From page 16	K 923	• Audits will be at the quarterly QAPI meetings to discuss audit findings and address any issues promptly. Person responsible for compliance: The Maintenance Supervisor is responsible for maintaining compliance with oxygen storage requirements. Date of completion: 7/22/25	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 5, 2025

Administrator
Redeemer Residence Inc
625 WEST 31ST STREET
Minneapolis, MN 55408

RE: CCN: 245520
Cycle Start Date: June 5, 2025

Dear Administrator:

On July 29, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore, no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us