Electronically delivered

January 21, 2021

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

RE: CCN: 245520
Cycle Start Date: December 8, 2020

Dear Administrator:

On December 29, 2020 and January3, 2021, we notified you remedies were imposed. On January 19, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 12, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 13, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 29, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 13, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 12, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing

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

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January 3, 2021

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

RE: CCN: 245520
Cycle Start Date: December 8, 2020

Dear Administrator:

On December 29, 2020, we informed you of imposed enforcement remedies.

On December 22, 2020, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 13, 2021, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 13, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 13, 2021.

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

As we notified you in our letter of December 29, 2020, in accordance with Federal law, as specified in

the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 13, 2021.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
Metro C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900

Saint Paul, Minnesota 55164-0900
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 8, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at 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.

APPEAL RIGHTS

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

receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 12/22/2020

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 000	INITIAL COMMENTS On 12/22/20, an abbreviated survey was completed at your facility to conduct complaint investigations. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint(s) was found to be SUBSTANTIATED: MN68185/H5520082C, MN64984/H5520083C, and MN60095/H5520084C, with deficiencies cited at F600 and F609. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and	F 600		1/12/21

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

Electronically Signed | 01/12/2021

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

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F 600	Continued From page 1 any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to prevent 2 of 5 residents (R1 and R4) reviewed, from being physically abused, when R2 hit R1, and when R5 hit R4. Further, the facility failed to prevent 1 of 5 residents (R2) reviewed, from being verbally abused. Findings Include: R1's annual Minimum Data Set (MDS) dated 10/13/20, included severe cognitive impairment, with diagnoses including, dementia, paranoid schizophrenia, and mild intellectual disabilities. R1 required extensive assist for all activities of daily living (ADL's). R1's care plan dated 10/15/20, included she was at risk for abuse/neglect. Staff were directed to explain all cares and procedures, only assign female caregivers, and assign regular caregivers as available. R2's quarterly MDS dated 10/30/20, included, moderate cognitive impairment with diagnoses including personal history of traumatic brain injury and psychotic disorder with hallucinations. R2 required extensive assist for all ADL's.	F 600	It is the practice of the facility to provide a safe environment that is free from abuse and harm to it's residents. Providing this level of care presents a daily challenge when residents have diagnoses of severe cognitive impairment, dementia, paranoid schizophrenia, and intellectual disabilities. To correct the situation R2 was assessed by nursing and social service who contacted the physician and it was determined to move R2 to another location within the facility away from R1. R2 has also been placed on 1:1 observation. Social Services is seeking relocation to a more appropriate facility as R2 is a young adult with a TBI. R2's medication regiment has been adjusted with assistance from the psychiatrist, being finally approved by his guardian who has previously resisted medication alignment and relocation. The facility also requested assistance from the Ombudsman regarding relocation. Related to R3 verbally accosting R2, social worker assessed R3's behaviors and addressed the situation with the resident and she then agreed to be moved to another unit and was happy to do so. The incident was a personality	

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F 600	Continued From page 2 R2's care plan dated 12/22/20, included, a potential to demonstrate physically abusive behaviors related to psychotic disorder with hallucinations and adjustment disorder with mixed disturbance of emotions. R2's care plan indicated R2's goal was to, "exhibit striking out less." Staff were directed to, "move resident to another area of the building if aggression towards other residents is expressed, update Associated Clinic of Psychology (ACP) on behaviors, move to a quiet environment if resident displays agitation, and to attempt to maintain consistent routine." R2's progress note dated 12/14/20, included, R2 was seen hitting R1 in the face with no reason. Then R2 was moved to a different unit. A typed statement from licensed practical nurse (LPN)-A dated 12/14/20, included LPN-A was in another resident and LPN-A heard a scream. LPN-A went to the dining room to assist however, R2 had already been removed from the dining room. LPN-A observed R1 for injuries and none were noted at the time of the altercation. A typed statement from dietary aide (DA)-A dated 12/21/20, included DA-A indicated the dining room was quiet and there were no loud noises or any words exchanged between R1 and R2 when DA-A witnessed R2 swing his arm back and backhanded R1 across the face. R1 then screamed, "ow" while holding her face. DA-A then assisted separating R1 and R2 and removed R2 from the dining room. A facility reported incident dated 12/14/20, at 6:15 p.m. included, R2 hit R1 in the face while in the dining room. R1 and R2 were separated immediately and R2 was moved to a different	F 600	conflict rather than a random incident. There have been no other incidents since the 2 residents are currently on the different units. Related to R4 and R5, Nursing assessment indicated that due to R5's behaviors being uncontrollable it was determined R5 should be relocated to another unit separating the 2 residents which has occured. Psychiatrist was contacted and assisted with ordering a medication change which has proved to be effective in maintaining a more normal behavior for R5 and there have been no other instances since. Another abuse assessment was conducted on 1/5/21 related to her abusive behaviors and risk of being abused. Compliance will be maintained through audits of the whole house behavior care plans at each quarterly conference with the care plan IDT. Care cards will be updated according to the plan of care. Staff will be educated on abuse prevention and reporting and audits conducted for understanding of VA policy.Results will be presented to the QAPI Committee who will then decide the duration of conducting further audits based on positive outcomes. Responsible person: DON and Director of Social Services	

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F 600	Continued From page 3	F 600		

unit.

A typed statement from nursing assistant (NA)-A dated 12/15/20, included NA-A indicated being in the dining room when R2 hit R1 in the face. NA-A was heating up R2's food when NA-A heard R1 scream. NA-A indicated not witnessing the actual altercation between R1 and R2. NA-A assisted separating R1 and R2 after the altercation.

When interviewed on 12/22/20, at 9:41 a.m. registered nurse (RN)-A stated, R2 hit R1 in the face on 12/14/20. Further stated, the first intervention was to move R2 off the unit from R1 and then R2 was referred to ACP for medication adjustment however, R2 family will not allow the medication adjustment. RN-A indicated no other interventions have been put into place at this time for R2.

When interviewed on 12/22/20, at 9:51 a.m. R1 stated, "[R2] hit me in the face on the left side of my head and I don't know why because I always treated [R2] nice."

When interviewed on 12/22/20, at 10:47 a.m. DA-A stated, "was waiting for the cart to come off the west elevator when I looked back in the dining room and witnessed [R2] slap [R1] in the face." Further DA-A stated, "It was quiet in the dining room prior to this happening."

When interviewed on 12/22/20, at 1:23 p.m. the director of nursing (DON) verified R2 did hit R1 in the face and stated, "Abuse should never happen."

R3's quarterly MDS dated 9/23/20, included, mild cognitive impairment with diagnoses including

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F 600	Continued From page 4 alcohol dependence with alcohol-induced persisting dementia and schizoaffective disorder. R3 required supervision dressing, bed mobility, and personal hygiene. R3's care plan dated 08/23/17, included, a potential to demonstrate rejection of care, delusional thinking, paranoia, and aggression towards others. R3's care plan indicated R3's goal was to, "be free of behaviors or not increase." Staff were directed to, "be mindful of their approach and use soft, compassionate approach, allow resident to vent feelings, and remove resident to room or private area for persistent or inappropriate behaviors." R3's progress note dated 9/6/20, at 8:10 p.m. included R3 was standing in the doorway, facing R2's door when R3 put up the middle finger and stated, "Fuck you," to R2 witnessed by NA-B. When interviewed on 12/22/20, at 10:14 a.m. R3 stated, "I didn't do anything wrong, [R2] started throwing stuff at me but [R2] is really mean." When interviewed on 12/22/20, at 9:23 a.m. R2 stated, "I remember the lady stuck her finger up at me but I don't know why." R4's quarterly MDS dated 11/6/20, included moderate cognitive impairment with a a diagnosis of multiple sclerosis and depression. R4's care plan dated 11/10/20, included R4 was at risk for	F 600		

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F 600	Continued From page 5	F 600		

abuse and neglect. R4's goal was to remain safe and free from abuse. Staff were directed to, explain cares and procedures, regular caregiver and to encourage resident to talk through anger and frustration.

R5's significant change MDS dated 10/21/20, included, moderate cognitive impairment and diagnosis of dementia and a stroke. R5's care plan dated 12/18/20, included behaviors of striking out, staff were directed to asses behaviors, intervene as needed, and document behaviors.

A facility incident report dated 4/10/20, indicated R4 alleged that R5 hit her. R4 and R5 were separated immediately. R4 was assess for injuries and no injuries were noted.

When interviewed on 12/23/20, at 9:32 a.m. R4 stated, "I really don't remember [the entire incident] I was surprised she hit me, right around to my chin. We were talking about something and then she got very upset and I was surprised that anyone reacted that way." R4 further recalled that R5 hit her with an open hand and R4 bruises easily but did not notice any bruises after the incident. R4 concluded the interview by sharing nothing of this nature has since occurred with other residents. R4 was unaware of the whereabouts of R5, only that she would recognize R5 if she were on her unit and did not recall seeing R5 recently.

When interviewed on 12/23/20, at 11:32 a.m. RN-B stated, R4 told her R5 had struck her in the face. R4 was a reliable reporter and R5 had a history of behaviors. RN-B had assessed R4 for injuries and none were noted.

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F 600	Continued From page 6 When interviewed on 12/23/20, at 12:09 p.m. licensed practical nurse (LPN)-C stated, reported she had not witnessed the altercation, but reported the incident to the Nursing Home Incident Reporting (NHIR) portal immediately after being informed. LPN-C stated she assessed the area on R4's face where she was hit and observed no injuries. LPN added she recalled interviewing R4 who confirmed her account of events. LPN-C also stated R4 reported to her she felt safe at the facility. The facility's Vulnerable adult policy revised 10/31/19, indicated, "the resident has the right to be free from verbal, physical, sexual, or mental abuse, neglect, misappropriation of resident property by anyone including staff, other residents, family, friends, volunteers, etc."	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and	F 609		1/12/21

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F 609	Continued From page 7 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to ensure allegations of potential verbal abuse were reported timely to the administrator and State agency (SA) for 1 of 5 residents (R2) whose allegations of abuse were reviewed. Findings include: R2's quarterly MDS dated 10/30/20, included, moderate cognitive impairment with diagnoses including personal history of traumatic brain injury and psychotic disorder with hallucinations. R2 required extensive assist for all ADL's. R2's care plan dated 2/7/20, included, a potential to demonstrate physically abusive behaviors related to psychotic disorder with hallucinations and adjustment disorder with mixed disturbance of emotions. R2's care plan indicated R2's goal was to, "exhibit striking out less" Staff were directed to, "move resident to another area of the building if aggression towards other residents is expressed, update Associated Clinic of Psychology (ACP) on behaviors, move to a quiet	F 609	It is the practice of the facility to report all abuse allegations immediately to the appropriate agencies and facility staff. Policies and procedures were reviewed with no changes. The deficiency occurred because they were not followed. The Staff responsible for not reporting in a timely manner has been re-educated of the proper procedures. All staff are being re-educated on the procedures for proper reporting of VA incidents. Staff interviews and audits for understanding of the VA policy are being conducted by Social Services. At least 6 audits/interviews will be conducted in week 1; 4 for week 2; and 2 audits/interviews for weeks 3 and 4. Results will be presented to the QAPI Committee who will then decide the duration of conducting further audits based on positive outcomes. Responsible persons: Directors of Nursing and Social Services.	

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 12/22/2020

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F 609	Continued From page 8	F 609		

environment if resident displays agitation, and to attempt to maintain consistent routine."

R3's quarterly MDS dated 9/23/20, included, mild cognitive impairment with diagnoses including alcohol dependence with alcohol-induced persisting dementia and schizoaffective disorder. R3 required supervision dressing, bed mobility, and personal hygiene.

R3's care plan dated 8/23/17, included, a potential to demonstrate rejection of care, delusional thinking, paranoia, and aggression towards others. R3's care plan indicated R3's goal was to, "be free of behaviors or not increase." Staff were directed to, "be mindful of their approach and use soft, compassionate approach, allow resident to vent feelings, and remove resident to room or private area for persistent or inappropriate behaviors."

Facility reported incident, included R3 had shown R2 her middle finger and swore at R3 on 9/6/20, at 7:30 p.m. However this was not reported to the state agency until 9/8/20, at 9:15 a.m.

When interviewed on 12/22/20, at 11:30 a.m. social services director (SSD) indicated, licensed practical nurse (LPN)-B did not feel R3 had any intent to cause harm to R2 so LPN-B did not call the administrator or the director of nursing (DON) to report the incident. SSD further indicated, after hearing about the incident and investigating it further SSD felt it needed to be reported to the SA due to potential verbal abuse. So, SSD reported the incident on 9/8/20.

When interviewed on 12/22/20, at 1:23 p.m. the director of nursing (DON) verified any type of

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F 609	Continued From page 9 abuse should be reported immediately to the SA. The facility Vulnerable Adult policy dated 11/21/18, indicated, "each employee is responsible to report suspected/alleged violations of mistreatment, neglect, exploitation of residents, and abuse of residents and/or misappropriation of resident property immediately, but no longer than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.	F 609		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 3, 2021

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

Re: Event ID: Q06I11

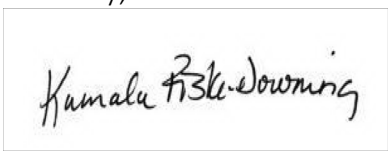
Dear Administrator:

The above facility survey was completed on December 22, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,



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

Minnesota Department of Health

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	00160	A. BUILDING: _____ B. WING _____	C 12/22/2020

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/22/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be IN compliance with the MN State Licensure. The following complaint(s) was found to be SUBSTANTIATED: MN68185/H5520082C,	2 000		

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

Electronically Signed | 01/12/21

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2 000	Continued From page 1 MN64984/H55220083C, and MN60095/H5520084C. NO licensing orders were issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		