Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 20, 2024

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

RE: CCN: 245520
Cycle Start Date: March 8, 2024

Dear Administrator:

On April 24, 2024, we notified you a remedy was imposed. On June 17, 2024 the Minnesota Departments of Health and Public Safety 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 June 7, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 8, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 24, 2024, 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 June 8, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on June 7, 2024, 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 Therefore, the NATCEP prohibition is rescinded.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 Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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June 20, 2024

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

Re: Reinspection Results
Event ID: JI1F12 and QN4G12

Dear Administrator:

On April 25, 2024 and June 13, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the surveys completed on March 8, 2024 and April 11, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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March 20, 2024

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

RE: CCN: 245520
Cycle Start Date: March 8, 2024

Dear Administrator:

On March 8, 2024, a survey was completed at your facility by the Minnesota Department of Health 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 June 8, 2024 (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 September 8, 2024 (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) / 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 electronic 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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 20, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: JI1F11

Dear Administrator:

The above facility was surveyed on March 6, 2024 through March 8, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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.

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00160	A. BUILDING: _____ B. WING _____	03/08/2024

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) COMPLETE DATE
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 3/6/24 through 3/8/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed. H55201540C (MN00100750) H55201541C (MN00101387) with a licensing order issued at (1475). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

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2 000	Continued From page 2 not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21475	MN Rule 4658.1005 Subp. 1 Social Services: General Requirements Subpart 1. General requirements. A nursing home must have an organized social services department or program to provide medically related social services to each resident. A nursing home must make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure comprehensive trauma assessments were completed to ensure appropriate treatment and services for 6 of 6 residents (R1, R2, R3, R4, R5 and R6) who had a history of traumatic events. Findings include: Facility matrix for providers identified one resident triggered for post traumatic stress disorder (PTSD)/Trauma in the facility. R1's face sheet identified R1 had diagnoses that included cerebral palsy, mood disorder due to	21475	CORRECTED	4/22/24

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21475	Continued From page 3 known physiological condition and anxiety. R1's quarterly Minimum Data Set (MDS) dated 12/27/23, identified R1 was cognitive and did not display behaviors. R1's abuse assessment observation dated 4/26/23, identified R1 had a history of being abused by others. Stepfather was an alcoholic and he was in the service so he would hurt her because she was from Yugoslavia. Although R1's record identified R1 had a history of past abuse a comprehensive trauma assessment that would identify potential triggers and interventions in order to attain or maintain the highest practicable mental and psychosocial well-being R1's care plan dated 9/27/23, identified R1 was at risk for abuse, had a history of abuse or neglect, and reported history of physical abuse from her father. R1 was alert and oriented and would be able to report abuse/neglect. R1's care plan did not address trauma related goals and interventions. Facility reported incident (FRI) dated 2/10/24, identified R1 reported yesterday a staff member asked R1 if he could touch her private part. R1 said no and he left the room. The staff member returned and asked R1 if she would touch his private part. R1 told him no and left the room. There was no physical sexual contact in the genital or breast area. There are no physical injuries at this time. A staff member was currently with R1 to get a full picture of emotional well-being. Progress note dated 2/11/24, identified R1	21475		

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21475	Continued From page 4 refused to be changed in the overnight shift in the presence of the writer and nursing assistant that shift. Progress note dated 2/14/24, indicated social worker met with resident on 2/12/24 to review incident (from 2/11/24) and check on psychosocial well-being. Resident reviewed with social worker the above incident. Social worker asked resident if she feel safe and she responded yes. Resident was not in any distress and was ready to eat her lunch. R1's record did not identify completion of a PHQ-9 (mood) assessment and/or a trauma assessment following the allegation. During interview on 3/6/24 at 9:12 a.m., R1 reported an allegation of unwanted touching and sexual requests which made R1 uncomfortable. During interview R1 mentioned a history of sexual abuse by father which led to R1 having ongoing fears regarding males throughout R1's life. During interview on 3/8/24 at 8:47 a.m., family member (FM)-A stated R1 was mentally and physically handicap and very vulnerable. FM-A reported R1 had made multiple allegations about male staff touching her and responding inappropriately. FM-A was unsure if these allegations were due to a new experience, or the allegations were a result of R1's past history with her father because there was strong suspicion R1 had been raped by him. Since FM-A was not sure if R1's allegations were a result of past trauma or if allegations of sexually inappropriate behaviors by staff were true, FM-A immediately reported to facility staff for further investigation. During interview on 3/6/24 at 12:24 p.m., director	21475		

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21475	Continued From page 5 of nursing (DON) reported R1's abuse allegation ultimately ended up being unsubstantiated by the facility, and it was identified the allegation may be due to R1's past history of trauma. R1 declined ACP (associated clinic-psychology) services and on call provider was notified. R2's face sheet identified R2 had a diagnosis which included traumatic hemorrhage of cerebrum (bleeding in the brain), with loss of consciousness of unspecified duration. Diffuse traumatic brain injury with loss of consciousness of unspecified duration. R2 had aphasia following cerebral infarction. R2's entry tracking Minimum Data Set (MDS) dated 1/5/24, did not identify a brief interview for mental status was conducted (BIMS). R2 required substantial/maximal assistance for toilet hygiene, partial to moderate assistance for lower body dressing and supervision or touching assistance for personal hygiene. During interview on 3/6/24 at 10:16 a.m., R2 had difficulty with speaking related to medical diagnosis. R2 reported being inappropriately touched by a male staff member. R2 felt uncomfortable and scared. R2 indicated she did not want men in her room. R2's care plan dated 8/28/23, identified R2 was admitted for rehabilitation and skilled care due to traumatic subdural hemorrhage with loss of consciousness of unspecified duration. Interdisciplinary team was to assist resident with discharge planning. R2 was at risk for mood disturbance related to diagnosis of depression. Potential alteration in mood exhibited by flat affect. Staff will work with resident and family to identify causes of mood problems an identify	21475		

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21475	Continued From page 6 effective interventions and coping strategies. R2's communication had improved some and can get general message and feelings out verbally. R2 does understand. Staff are to report any changes in ability to communicate and understand others. R2's abuse assessment observation dated 8/30/23, identified R2 had a history of being abused by others and R1 had physical and cognitive disabilities which made R2 susceptible to abuse. R2 did not have any behaviors which made R2 susceptible to abuse. R1 had communication limitations which increased R2's susceptibility to abuse including wearing glasses and R2's hearing was fair. R2's PHQ-9 (mood interview) score dated 12/29/23, with a score of 5 indicating major depressive syndrome. In review of R2's record it was not evident a comprehensive trauma assessment had been completed. R2's progress note dated 2/28/24, identified staff member found urine on the floor in R2's room. Reminded resident to ask for assistance for any needs. R2's progress note dated 3/4/24, identified R2 had been refusing cares while laying down in bed. Resident refused pad changing, blood sugar, g-tube flushing, dressing and lunch. Risk and benefit explained, redirected, and encouragement done but with no affect. Monitoring continues. During interview on 3/7/24 at 12:54 p.m., R2's power of attorney (POA) indicated they were responsible for R2's health care decisions. POA reported R2 did not like men in her room nor like	21475		

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21475	Continued From page 7 men around her. POA explained R2's fear of men started in July of 2023 when R2 was attacked at a party and was raped, causing her to need admission into the nursing facility. POA stated R2 started "pointing at" male care givers in the past two weeks. One time when POA was present in R2's room with a male staff, R2 pointed at the staff and said things like, "I don't want this!", "Leave!", "Not you!" POA remembered another instance when R2 said "sex me" and pointed at her vagina. POA reported R2 had only been pointing and refusing care from male staff. POA felt this may be due to R2's experience of being raped. FM-B reported never being asked by facility staff about R2's trauma or what events led to R2's admission to the facility. FM-B did not feel the facility staff had awareness of R2's recent history of rape and maybe why R2 had been refusing personal cases, such as using the restroom, from men. R3's face sheet identified R3 had neurocognitive disorder with lewy bodies and dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. R3's significant change Minimum Data Set (MDS) dated 2/19/24, identified severe cognitive impairment. R3 was dependent for toilet hygiene, required substantial/maximal assistance to shower and bathe self as well as upper body and lower body dressing. R3's abuse/psychosocial well-being care plan dated 11/29/21, indicated was at risk for abuse or neglect due to vulnerable status living in skilled nursing facility. R3 had occasional periods of confusion and delusional thoughts. R3 had a history of abuse or neglect from childhood and	21475		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00160	A. BUILDING: _____ B. WING _____	03/08/2024

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) COMPLETE DATE
21475	Continued From page 8 spousal abuse. R3 had periods of night mare. The care plan intervention directed staff to complete abuse prevention observation per protocol. R3's abuse assessment dated 1/17/23, identified R3 had history of self-abuse and refusing care. R3 had a history of being abused by others [childhood and spouse]. R3 did have physical limitations, cognitive deficits, and communication limitations. Although R3's abuse assessment and care plan identified R3 had a history of abuse, there was no indication a comprehensive trauma assessment had been completed. During interview on 3/6/24 at 1:12 p.m., R3 reported she did not want male staff members to touch her for any reason. R3 reported uncomfortable and unwanted touch by a male staff member and facility staff have not asked her about her concerns with male caregivers. R4's face sheet identified R4 to have dementia, borderline personality disorder, bipolar disorder and anxiety disorder. R4's quarterly MDS dated 2/1/24, did not identify R4's cognitive level and R4 did not have behaviors. R4 was dependent on toilet hygiene, upper body and lower body dressing and personal hygiene. R4's psychosocial care plan dated 11/21/19, identified R4 had a history of trauma; physical abuse as a child. Corresponding interventions directed staff to assist R4 to talk with daughters to provide comfort. The care plan indicated R4 had difficulty identifying triggers and preferred to keep	21475		

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21475	Continued From page 9 things to herself. R4 declined assistance from mental health professionals. R4's behavior care plan dated 3/24/23, identified R4 had behaviors of refusing hygiene cares. R4 had aggressive behaviors of yelling. This was due to borderline personality disorder. Staff are to work with resident/family to identify situations which trigger behavioral expression and to identify coping skills which have worked in the past. Staff to assist resident using these coping skills. Although R4's care plan identified R4 had a history of trauma, in review of R4's record it was not evident a comprehensive trauma assessments were completed to assist R4 in the determination of triggers and appropriate interventions identified to attain or maintain the highest practicable mental and psychosocial well-being. During interview on 3/7/24 at 10:56 a.m., family member FM-(C) indicated R4 had a past history of trauma including being molested as a child. During interview on 3/6/24 at 10:34 a.m., nursing assistant NA-(A) reported R4 was resistive with cares and refused personal cares. NA-A was not sure if there was a reason for R4's refusals. During interview 3/7/24 at 9:25 a.m., clinical manager (CM)-A reported R4 was very resistive with care including personal cares. CM-A was aware of some sexual and physical abuse reported to her by FM-C, however, could not recall the specifics and was not aware of any specific interventions relating to the past abuse. R5's face sheet identified R5 had vascular dementia, without behavioral disturbance, psychotic disturbance, mood disturbance, and	21475		

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21475	Continued From page 10 anxiety. R5's quarterly MDS dated 1/10/24, identified R5 was cognitively intact. R5 required substantial/maximal assistance for toilet hygiene and bathing. R5 required substantial/maximal assistance for lower body dressing. R5's Abuse Observation dated 6/19/23, identified R5 had a history of being abused by others, Resident explained she had been abused by previous partners. R5's Social History and Psycho-Social Assessment Observation dated 6/19/23 identified R5 did not have a history of trauma or significant life event. R5's psychosocial care plan dated 6/9/23, was inconsistent with Abuse Observation dated 6/19/23; R5's care plan identified R5 had no known history of abuse or neglect. The care plan identified R5 was at risk for abuse/neglect due to vulnerable status living in a skilled nursing facility. Although R5's Abuse Observation dated 6/19/23, identified R5 had a history of being abused, in review of R5's record, it was evident a comprehensive trauma assessment had been completed. During interview on 3/7/24 at 2:20 p.m., R5 reported she did not feel comfortable with male care providers and did not want them assisting with personal cares because it made her feel uncomfortable. R5 explained if a male staff attempted to provide cares or take her to the bathroom she would tell them she did not want them in her room.	21475		

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21475	Continued From page 11 R6's face sheet identified R6 had major depressive disorder moderate. R6's quarterly MDS dated 1/10/24, identified R6 to have moderate cognitive impairment. R6 was dependent for toilet hygiene, required substantial/maximal assistance to shower, and dependent for lower body dressing. R6's care plan dated 11/29/2021 identified R6 has no known history of abuse or neglect. Is at risk for abuse/neglect due to vulnerable status living in a skilled nursing facility, impaired mobility, weakness, require 24 hour care. Is able to identify unsafe situations. Is alert and oriented and would be able to report abuse/neglect. Resident has a history of self-abuse with refusal of cases. R6 Abuse Observation dated 10/13/22, identified R6 did not have a history of abuse. R6's chart lacked trauma assessments. During interview on 3/7/24 at 11:45 a.m., R6 reported a past history of sexual trauma specifically with men. R6 stated she had multiple experiences with this type of trauma with a person she had trusted and had a lot of respect for. R6 explained due to her experiences she has lost all respect for any man. R6 explained she felt comfortable with only one of the male staff members providing her personal cares because she had developed reporrt with him. R6 stated the facility has not offered help to deal with her past trauma. During interview on 3/7/24 at 10:00 a.m., nursing assistant NA-(B) reported there were several women residents in the facility who did not like help or assistants from male staff. NA-B	21475		

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21475	Continued From page 12 specifically named R1, R5, and R6. NA-B was aware R6 was "okay" with one male staff, but preferred females for personal cares. NA-B explained was aware of this information because she talked with residents who shared their past experiences. NA-B was unsure on how to provide trauma related care to residents who had a history of traumatic experiences and reported direct care staff did not receive that kind of information nor was it identified in resident care plans. During interview on 3/7/24 at 1:22 p.m., clinical manager CM-(B) was unaware of any residents who did not want male care givers. CM-B stated an awareness R2 had been assaulted; CM-B stated R2 did not address R2's history of trauma however CM-B was aware R2's history of sexual assault. CM-B reported R2 should have a trauma informed care plan given the details of R2's attack. CM-B stated if the facility were not aware of pas history of trauma, and the care plan was incorrect, they could unintentionally trigger a flashback. If a resident had a history of assault or abuse, the trauma should be identified on the care plan with appropriate interventions in order to mitigate the risks of retraumatization and/or coping with the trauma. During interview on 3/8/24 at 12:03 p.m., social worker SW-(A) reported R1's abuse observation identified past history of abuse and information was not passed on by the temporary social worker at the time. Floor staff would not know about this history as it was not care planned. Without having the past history of sexual abuse, R1 could be uncomfortable with male workers. Additionally, it could lead to allegations of abuse if the care provided unintentionally triggered a memory from R1's past. SW-A reviewed R2's,	21475		

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21475	Continued From page 13 R3's, R4's, R5's, and R6's records and indicated there were unclear details about the abuse and the ongoing potential for trauma was not identified as a factor. SW-A explained without having appropriate interventions in place, residents could be retraumatized and it was best to know so individualized care and mental health services could be provided. During interview on 3/8/24 at 12:50 p.m. director of nursing (DON) explained there was a difference between between trauma care plans and vulnerability care plans. Trauma care plans specifically identified the trauma, addressed what the resident had been through, triggers, and how facility staff were to provide cares without causing stress to the resident. A vulnerability care plan identified the resident's vulnerability due to living in a nursing home and disabilities which may make them susceptible. It was important the facility identified the appropriate care plan and be more specific about the individualized needs. Staff needed to be aware of how to approach someone appropriately. Facility policy dated 10/14/22 titled Trauma Informed Care 1. Cassia facilities support a culture of emotional well-being and physical safety for staff, residents and visitors. 2. Trauma-informed care is culturally sensitive and person-centered. 3. Caregivers are taught strategies to help eliminate, mitigate or sensitively address a resident's triggers. 4. Trauma informed care is included in our QAPI program so that needs and Problem areas are identified and addressed. 5. The facility assessment will include a review of	21475		

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21475	Continued From page 14 Trauma Informed care practices. 6. Each facility works with community support organizations and appropriate referral Agencies for services, referrals and education as indicated. 7. As a part of the admission comprehensive assessment the facility will identify history of trauma or interpersonal violence when possible using the Social history and psycho-social observation tool. 8. If a resident shares a history of trauma, a trauma informed care plan will be Developed with appropriate information to help guide staff in an effort to avoid Re-traumatization. 9. It is Cassia's expectation that our staff interact with all residents and visitors in a manner that is welcoming and kind without being intrusive. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review/revise policies and procedures on implementing trauma informed care. The administrator or designee could educate all staff on these policies and procedures. The administrator or designee could audit to ensure all residents are being provided with trauma informed care, and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21475		

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F 000	INITIAL COMMENTS On 3/6/24 through 3/8/24 , a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H55201540C (MN00100750) and H55201541C (MN00101387) with a deficiency issued at F742. 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 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 742 SS=E	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;	F 742		4/22/24

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

Electronically Signed | 03/27/2024

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 742	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure comprehensive trauma assessments were completed to ensure appropriate treatment and services for 6 of 6 residents (R1, R2, R3, R4, R5 and R6) who had a history of traumatic events. Findings include: Facility matrix for providers identified one resident triggered for post traumatic stress disorder (PTSD)/Trauma in the facility. R1's face sheet identified R1 had diagnoses that included cerebral palsy, mood disorder due to known physiological condition and anxiety. R1's quarterly Minimum Data Set (MDS) dated 12/27/23, identified R1 was cognitive and did not display behaviors. R1's abuse assessment observation dated 4/26/23, identified R1 had a history of being abused by others. Stepfather was an alcoholic and he was in the service so he would hurt her because she was from Yugoslavia. Although R1's record identified R1 had a history of past abuse a comprehensive trauma assessment that would identify potential triggers and interventions in order to attain or maintain the highest practicable mental and psychosocial well-being R1's care plan dated 9/27/23, identified R1 was at risk for abuse, had a history of abuse or neglect, and reported history of physical abuse from her	F 742	F742 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Redeemer Health and Rehab to comply with (F742) To assure continued compliance, the following plan has been put into place; Regarding cited resident: Comprehensive trauma assessments will be completed and implemented for residents R1, R2, R3, R4, R5, and R6. Actions taken to identify other potential residents having similar occurrences: Administrator, DON, Social Workers, and Clinical Managers will review all current resident abuse assessments to determine whether or not a comprehensive trauma assessment is necessary. All residents with trauma history will have a trauma informed care plan in place. Measures put in place to ensure deficient practice does not recur: Abuse and Trauma assessments done upon admission and quarterly with trauma care plans in place if needed. All staff re-education on trauma informed care beginning 3/8/24 through 4/22/24. As of 4/22/24 any required staff that did not attend re-education will be educated prior	

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F 742	Continued From page 2 father. R1 was alert and oriented and would be able to report abuse/neglect. R1's care plan did not address trauma related goals and interventions. Facility reported incident (FRI) dated 2/10/24, identified R1 reported yesterday a staff member asked R1 if he could touch her private part. R1 said no and he left the room. The staff member returned and asked R1 if she would touch his private part. R1 told him no and left the room. There was no physical sexual contact in the genital or breast area. There are no physical injuries at this time. A staff member was currently with R1 to get a full picture of emotional well-being. Progress note dated 2/11/24, identified R1 refused to be changed in the overnight shift in the presence of the writer and nursing assistant that shift. Progress note dated 2/14/24, indicated social worker met with resident on 2/12/24 to review incident (from 2/11/24) and check on psychosocial well-being. Resident reviewed with social worker the above incident. Social worker asked resident if she feel safe and she responded yes. Resident was not in any distress and was ready to eat her lunch. R1's record did not identify completion of a PHQ-9 (mood) assessment and/or a trauma assessment following the allegation. During interview on 3/6/24 at 9:12 a.m., R1 reported an allegation of unwanted touching and sexual requests which made R1 uncomfortable. During interview R1 mentioned a history of sexual	F 742	to working again. Effective implementation of actions will be monitored by: The social workers will audit to ensure all necessary residents have comprehensive trauma assessments and care plans weekly x 4 weeks and then monthly x 2 months. Results of these audits will be reviewed by the facility QAPI committee. The QAPI committee will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Administrator, or designee, is responsible to maintain compliance. Completion date for certification purposes only is: 4-22-2024	

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F 742	Continued From page 3 abuse by father which led to R1 having ongoing fears regarding males throughout R1's life. During interview on 3/8/24 at 8:47 a.m., family member (FM)-A stated R1 was mentally and physically handicap and very vulnerable. FM-A reported R1 had made multiple allegations about male staff touching her and responding inappropriately. FM-A was unsure if these allegations were due to a new experience, or the allegations were a result of R1's past history with her father because there was strong suspicion R1 had been raped by him. Since FM-A was not sure if R1's allegations were a result of past trauma or if allegations of sexually inappropriate behaviors by staff were true, FM-A immediately reported to facility staff for further investigation. During interview on 3/6/24 at 12:24 p.m., director of nursing (DON) reported R1's abuse allegation ultimately ended up being unsubstantiated by the facility, and it was identified the allegation may be due to R1's past history of trauma. R1 declined ACP (associated clinic-psychology) services and on call provider was notified. R2's face sheet identified R2 had a diagnosis which included traumatic hemorrhage of cerebrum (bleeding in the brain), with loss of consciousness of unspecified duration. Diffuse traumatic brain injury with loss of consciousness of unspecified duration. R2 had aphasia following cerebral infarction. R2's entry tracking Minimum Data Set (MDS) dated 1/5/24, did not identify a brief interview for mental status was conducted (BIMS). R2 required substantial/maximal assistance for toilet hygiene, partial to moderate assistance for lower body	F 742		

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F 742	Continued From page 4 dressing and supervision or touching assistance for personal hygiene. During interview on 3/6/24 at 10:16 a.m., R2 had difficulty with speaking related to medical diagnosis. R2 reported being inappropriately touched by a male staff member. R2 felt uncomfortable and scared. R2 indicated she did not want men in her room. R2's care plan dated 8/28/23, identified R2 was admitted for rehabilitation and skilled care due to traumatic subdural hemorrhage with loss of consciousness of unspecified duration. Interdisciplinary team was to assist resident with discharge planning. R2 was at risk for mood disturbance related to diagnosis of depression. Potential alteration in mood exhibited by flat affect. Staff will work with resident and family to identify causes of mood problems an identify effective interventions and coping strategies. R2's communication had improved some and can get general message and feelings out verbally. R2 does understand. Staff are to report any changes in ability to communicate and understand others. R2's abuse assessment observation dated 8/30/23, identified R2 had a history of being abused by others and R1 had physical and cognitive disabilities which made R2 susceptible to abuse. R2 did not have any behaviors which made R2 susceptible to abuse. R1 had communication limitations which increased R2's susceptibility to abuse including wearing glasses and R2's hearing was fair. R2's PHQ-9 (mood interview) score dated 12/29/23, with a score of 5 indicating major depressive syndrome.	F 742		

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F 742	Continued From page 5 In review of R2's record it was not evident a comprehensive trauma assessment had been completed. R2's progress note dated 2/28/24, identified staff member found urine on the floor in R2's room. Reminded resident to ask for assistance for any needs. R2's progress note dated 3/4/24, identified R2 had been refusing cares while laying down in bed. Resident refused pad changing, blood sugar, g-tube flushing, dressing and lunch. Risk and benefit explained, redirected, and encouragement done but with no affect. Monitoring continues. During interview on 3/7/24 at 12:54 p.m., R2's power of attorney (POA) indicated they were responsible for R2's health care decisions. POA reported R2 did not like men in her room nor like men around her. POA explained R2's fear of men started in July of 2023 when R2 was attacked at a party and was raped, causing her to need admission into the nursing facility. POA stated R2 started "pointing at" male care givers in the past two weeks. One time when POA was present in R2's room with a male staff, R2 pointed at the staff and said things like, "I don't want this!", "Leave!", "Not you!" POA remembered another instance when R2 said "sex me" and pointed at her vagina. POA reported R2 had only been pointing and refusing care from male staff. POA felt this may be due to R2's experience of being raped. FM-B reported never being asked by facility staff about R2's trauma or what events led to R2's admission to the facility. FM-B did not feel the facility staff had awareness of R2's recent history of rape and maybe why R2 had been	F 742		

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F 742	Continued From page 6 refusing personal cases, such as using the restroom, from men. R3's face sheet identified R3 had neurocognitive disorder with lewy bodies and dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. R3's significant change Minimum Data Set (MDS) dated 2/19/24, identified severe cognitive impairment. R3 was dependent for toilet hygiene, required substantial/maximal assistance to shower and bathe self as well as upper body and lower body dressing. R3's abuse/psychosocial well-being care plan dated 11/29/21, indicated was at risk for abuse or neglect due to vulnerable status living in skilled nursing facility. R3 had occasional periods of confusion and delusional thoughts. R3 had a history of abuse or neglect from childhood and spousal abuse. R3 had periods of night mare. The care plan intervention directed staff to complete abuse prevention observation per protocol. R3's abuse assessment dated 1/17/23, identified R3 had history of self-abuse and refusing care. R3 had a history of being abused by others [childhood and spouse]. R3 did have physical limitations, cognitive deficits, and communication limitations. Although R3's abuse assessment and care plan identified R3 had a history of abuse, there was no indication a comprehensive trauma assessment had been completed.	F 742		

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F 742	Continued From page 7 During interview on 3/6/24 at 1:12 p.m., R3 reported she did not want male staff members to touch her for any reason. R3 reported uncomfortable and unwanted touch by a male staff member and facility staff have not asked her about her concerns with male caregivers. R4's face sheet identified R4 to have dementia, borderline personality disorder, bipolar disorder and anxiety disorder. R4's quarterly MDS dated 2/1/24, did not identify R4's cognitive level and R4 did not have behaviors. R4 was dependent on toilet hygiene, upper body and lower body dressing and personal hygiene. R4's psychosocial care plan dated 11/21/19, identified R4 had a history of trauma; physical abuse as a child. Corresponding interventions directed staff to assist R4 to talk with daughters to provide comfort. The care plan indicated R4 had difficulty identifying triggers and preferred to keep things to herself. R4 declined assistance from mental health professionals. R4's behavior care plan dated 3/24/23, identified R4 had behaviors of refusing hygiene cares. R4 had aggressive behaviors of yelling. This was due to borderline personality disorder. Staff are to work with resident/family to identify situations which trigger behavioral expression and to identify coping skills which have worked in the past. Staff to assist resident using these coping skills. Although R4's care plan identified R4 had a history of trauma, in review of R4's record it was not evident a comprehensive trauma assessments were completed to assist R4 in the determination of triggers and appropriate	F 742		

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F 742	Continued From page 8 interventions identified to attain or maintain the highest practicable mental and psychosocial well-being. During interview on 3/7/24 at 10:56 a.m., family member FM-(C) indicated R4 had a past history of trauma including being molested as a child. During interview on 3/6/24 at 10:34 a.m., nursing assistant NA-(A) reported R4 was resistive with cares and refused personal cares. NA-A was not sure if there was a reason for R4's refusals. During interview 3/7/24 at 9:25 a.m., clinical manager (CM)-A reported R4 was very resistive with care including personal cares. CM-A was aware of some sexual and physical abuse reported to her by FM-C, however, could not recall the specifics and was not aware of any specific interventions relating to the past abuse. R5's face sheet identified R5 had vascular dementia, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R5's quarterly MDS dated 1/10/24, identified R5 was cognitively intact. R5 required substantial/maximal assistance for toilet hygiene and bathing. R5 required substantial/maximal assistance for lower body dressing. R5's Abuse Observation dated 6/19/23, identified R5 had a history of being abused by others, Resident explained she had been abused by previous partners. R5's Social History and Psycho-Social Assessment Observation dated 6/19/23 identified	F 742		

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F 742	Continued From page 9 R5 did not have a history of trauma or significant life event. R5's psychosocial care plan dated 6/9/23, was inconsistent with Abuse Observation dated 6/19/23; R5's care plan identified R5 had no known history of abuse or neglect. The care plan identified R5 was at risk for abuse/neglect due to vulnerable status living in a skilled nursing facility. Although R5's Abuse Observation dated 6/19/23, identified R5 had a history of being abused, in review of R5's record, it was evident a comprehensive trauma assessment had been completed. During interview on 3/7/24 at 2:20 p.m., R5 reported she did not feel comfortable with male care providers and did not want them assisting with personal cares because it made her feel uncomfortable. R5 explained if a male staff attempted to provide cares or take her to the bathroom she would tell them she did not want them in her room. R6's face sheet identified R6 had major depressive disorder moderate. R6's quarterly MDS dated 1/10/24, identified R6 to have moderate cognitive impairment. R6 was dependent for toilet hygiene, required substantial/maximal assistance to shower, and dependent for lower body dressing. R6's care plan dated 11/29/2021 identified R6 has no known history of abuse or neglect. Is at risk for abuse/neglect due to vulnerable status living in a skilled nursing facility, impaired mobility, weakness, require 24 hour care. Is able to identify	F 742		

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F 742	Continued From page 10 unsafe situations. Is alert and oriented and would be able to report abuse/neglect. Resident has a history of self-abuse with refusal of cases. R6 Abuse Observation dated 10/13/22, identified R6 did not have a history of abuse. R6's chart lacked trauma assessments. During interview on 3/7/24 at 11:45 a.m., R6 reported a past history of sexual trauma specifically with men. R6 stated she had multiple experiences with this type of trauma with a person she had trusted and had a lot of respect for. R6 explained due to her experiences she has lost all respect for any man. R6 explained she felt comfortable with only one of the male staff members providing her personal cares because she had developed reporrt with him. R6 stated the facility has not offered help to deal with her past trauma. During interview on 3/7/24 at 10:00 a.m., nursing assistant NA-(B) reported there were several women residents in the facility who did not like help or assistants from male staff. NA-B specifically named R1, R5, and R6. NA-B was aware R6 was "okay" with one male staff, but preferred females for personal cares. NA-B explained was aware of this information because she talked with residents who shared their past experiences. NA-B was unsure on how to provide trauma related care to residents who had a history of traumatic experiences and reported direct care staff did not receive that kind of information nor was it identified in resident care plans. During interview on 3/7/24 at 1:22 p.m., clinical	F 742		

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F 742	Continued From page 11 manager CM-(B) was unaware of any residents who did not want male care givers. CM-B stated an awareness R2 had been assaulted; CM-B stated R2 did not address R2's history of trauma however CM-B was aware R2's history of sexual assault. CM-B reported R2 should have a trauma informed care plan given the details of R2's attack. CM-B stated if the facility were not aware of pas history of trauma, and the care plan was incorrect, they could unintentionally trigger a flashback. If a resident had a history of assault or abuse, the trauma should be identified on the care plan with appropriate interventions in order to mitigate the risks of retraumatization and/or coping with the trauma. During interview on 3/8/24 at 12:03 p.m., social worker SW-(A) reported R1's abuse observation identified past history of abuse and information was not passed on by the temporary social worker at the time. Floor staff would not know about this history as it was not care planned. Without having the past history of sexual abuse, R1 could be uncomfortable with male workers. Additionally, it could lead to allegations of abuse if the care provided unintentionally triggered a memory from R1's past. SW-A reviewed R2's, R3's, R4's, R5's, and R6's records and indicated there were unclear details about the abuse and the ongoing potential for trauma was not identified as a factor. SW-A explained without having appropriate interventions in place, residents could be retraumatized and it was best to know so individualized care and mental health services could be provided. During interview on 3/8/24 at 12:50 p.m. director of nursing (DON) explained there was a difference between between trauma care plans	F 742		

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F 742	Continued From page 12 and vulnerability care plans. Trauma care plans specifically identified the trauma, addressed what the resident had been through, triggers, and how facility staff were to provide cares without causing stress to the resident. A vulnerability care plan identified the resident's vulnerability due to living in a nursing home and disabilities which may make them susceptible. It was important the facility identified the appropriate care plan and be more specific about the individualized needs. Staff needed to be aware of how to approach someone appropriately. Facility policy dated 10/14/22 titled Trauma Informed Care 1. Cassia facilities support a culture of emotional well-being and physical safety for staff, residents and visitors. 2. Trauma-informed care is culturally sensitive and person-centered. 3. Caregivers are taught strategies to help eliminate, mitigate or sensitively address a resident's triggers. 4. Trauma informed care is included in our QAPI program so that needs and Problem areas are identified and addressed. 5. The facility assessment will include a review of Trauma Informed care practices. 6. Each facility works with community support organizations and appropriate referral Agencies for services, referrals and education as indicated. 7. As a part of the admission comprehensive assessment the facility will identify history of trauma or interpersonal violence when possible using the Social history and psycho-social observation tool. 8. If a resident shares a history of trauma, a	F 742		

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F 742	Continued From page 13 trauma informed care plan will be Developed with appropriate information to help guide staff in an effort to avoid Re-traumatization. 9. It is Cassia's expectation that our staff interact with all residents and visitors in a manner that is welcoming and kind without being intrusive.	F 742		