DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 6, 2025

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

RE: CCN: 245520
Cycle Start Date: March 25, 2025

Dear Administrator:

On April 24, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 6, 2025

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

Re: Reinspection Results
Event ID: ESCI12

Dear Administrator:

On April 24, 2025 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 survey completed on March 25, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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Electronically delivered
April 4, 2025

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

RE: CCN: 245520
Cycle Start Date: March 25, 2025

Dear Administrator:

On March 25, 2025, 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:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 25, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 25, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

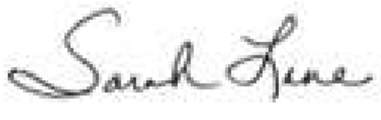
In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments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

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the

same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 4, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: ESCI11

Dear Administrator:

The above facility was surveyed on March 25, 2025 through March 25, 2025 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:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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.

Sincerely,

Sarah Lane

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 03/25/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 3/25/25, 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 complaint was reviewed: H55201881C (MN111662) with a deficiency issued at F880. 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 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		4/18/25

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

Electronically Signed | 04/11/2025

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

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F 880	Continued From page 1 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 2 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene was completed for 3 of 4 residents (R4, R5, R6). In addition, the facility failed to ensure proper personal protective equipment (PPE) was properly utilized for 1 of 4 resident (R4) reviewed for infection control. Findings include: R4 R4's admission Minimum Data Set (MDS) dated 2/24/25 indicated R4 was cognitively intact, had an indwelling catheter, and was dependent upon staff assistance for transfers. R4's Face Sheet printed 3/25/25, indicated diagnoses included pressure ulcer of sacrum and left thigh, and neuromuscular dysfunction of bladder. R4's care plan dated 2//21/25, indicated an indwelling catheter, and on 3/13/25, indicated	F 880	Plan of Correction for Deficiency F880 Facility Name: Redeemer Residence INC Regulation Cited: It is the policy of Cassia to comply with the Centers for Medicare & Medicaid Services (CMS) regulations regarding infection control, specifically ensuring proper hand hygiene and the use of personal protective equipment (PPE). Corrective Action for Affected Residents Residents Affected: R4, R5, R6 Immediate Actions Taken: Immediate re-education on proper hand hygiene and PPE techniques was provided to identified staff members involved in the care of residents R4, R5, and R6. Additional Actions Taken: Conducted a facility-wide audit to identify any other residents who may have been affected by similar deficiencies in hand hygiene and PPE usage. No additional residents were found to be affected.	

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F 880	Continued From page 3 enhanced barrier precautions (EBP) (measures intended to prevent the spread of multi-drug resistant organisms) related to a pressure ulcer. On 3/25/25 at 10:52 a.m., during an observation, there were two signs on R4's door that indicated the following: Enhanced Barrier Precautions (EBP) Sign 1: Families and Visitors, please follow enhanced barrier precautions. If you have questions, please see nurse. Everyone must clean their hands before entering room and when leaving the room. Providers and Staff please see reverse side for additional precautions required for this room. Sign 2: Providers and Staff: Wear gloves and a gown for the following high-contact resident care activities: Bathing/ showering, transferring residents from one position to another, changing bed linens, providing hygiene (only during high contact activities such as peri-care), changing briefs or assisting with toileting, caring for assisting with an indwelling medical device (for example central venous catheter, urinary catheter, feeding tube care, tracheostomy/ventilator care) and performing wound care. Put on in this order: Perform hand hygiene, gown, mask if needed or mask/eye shield if needed, gloves (if needed) Take OFF & dispose in this order: Gloves, mask/eye shield (if used), gown, mask(if used), perform hand hygiene (even if gloves used). On 3/25/25 at 11:18 a.m., during an observation nursing assistant (NA)-A entered R4's room, performed hand hygiene with alcohol based hand	F 880	Implemented Measures: Mandatory infection control training sessions for staff, focusing on hand hygiene and PPE protocols, to be completed on or before 4/18/2025. Installation of additional hand hygiene stations throughout the facility to encourage frequent handwashing. Regular reminders and visual aids posted in common areas and staff rooms to reinforce proper hand hygiene and PPE usage. Monitoring Plan: The Infection Control Nurse or designee will conduct random audits of at least 10 staff per week to ensure compliance with hand hygiene and PPE protocols. Results of these audits will be reviewed by the facility's Quality Assurance and Performance Improvement (QAPI) committee. The committee will determine if further monitoring or audits are necessary based on the findings. Person Responsible: The Director of Nursing or designee is responsible for maintaining compliance with infection control practices and ensuring the implementation of this plan of correction. Completion Date: All corrective actions will be completed by 04/18/2025, and ongoing monitoring will continue as outlined in the plan. By implementing these corrective actions and monitoring measures, Redeemer Residence INC is committed to ensuring compliance with CMS regulations and maintaining a safe environment for all residents and staff.	

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F 880	Continued From page 4 sanitizer (ABHS) , donned gloves and a gown, and entered R4's room. NA-A was already wearing a surgical mask. On 3/25/25 at 11:44 a.m., NA-A left R4's room, still wearing her mask, and used ABHS. On 3/25/25 at 11:45 a.m., during an interview, NA-A confirmed she wore the same mask all day. R5 R5's admission MDS dated 11/16/24, indicated R4 was cognitively intact, had an ostomy (an opening in the abdomen to allow waste to leave the body), and kidney insufficiency. R5's Face Sheet printed 3/25/25, indicated diagnoses that included an encounter for artificial opening of the urinary tract - ostomy, and cancer of the posterior wall of bladder. R5's care plan dated 11/12/24, indicated R5 was admitted to the facility for care after surgery on the nervous system, on 11/15/24 had a urostomy related to cancer on wall of the bladder, and on 3/13/25, was on EBP related to the ostomy. On 3/25/25 at 11:01 a.m., during an observation EBP precautions signs were noted on R5's door. Physical therapist (PT)-A pushed R5 in a wheelchair into R5's room, without performing hand hygiene. In addition, PT-A did not don PPE prior to entry to the room. PT-A donned gloves in the room and assisted R5 to transfer into bed. PT-A left the room without performing hand hygiene. PT-A did not wear a gown during the transfer.	F 880		

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F 880	Continued From page 5 On 3/25/25 at 11:56 a.m., during an interview PT-A acknowledged he had not performed hand hygiene nor donned a gown prior to entering R5's room. PT-A confirmed he had not performed hand hygiene when he left the room and stated he should have due to EBP in place, and to prevent the potential spread of infection. R6 R6's quarterly MDS dated 2/26/25, indicated R6 was cognitively intact, had an indwelling catheter, a neurogenic bladder (a condition that occurs when the nervous system's connection to the bladder is disrupted, causing bladder control issues), and quadriplegia. R6's Face sheet printed 3/25/25, indicated R6 had a pressure ulcer on the right buttock, neuromuscular dysfunction of bladder, and a urogenital (organs and functions related to both the urinary and reproductive systems) implant. R6's care plan dated 4/8/24, identified EBP were in place related to a suprapubic catheter and a wound. On 3/25/25 at 12:19 p.m., during an observation EBP signs were noted on R6's door. NA-B was observed to be passing meal trays from a cart in the hallway. NA-B picked up the meal tray prior to performing hand hygiene, entered R6's room, set the meal tray on R6's bedside table, and rearranged the items on the bedside table to make room for the meal tray. NA-B did not perform hand hygiene when she left the room. On 3/25/25 at 12:20 p.m., during an interview NA-B stated she washed her hands when she left	F 880		

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F 880	Continued From page 6 the kitchen, and because she was not performing direct care, she did not need to worry about hand hygiene before or after she left the room. NA-B stated she had training about hand hygiene a week or two ago, was taught to read the signs on the door prior to entering the rooms, and acknowledged she had not. On 3/25/25 at 3:27 p.m., registered nurse (RN)-A stated EBP was for residents with "tubes and wounds" however, staff should perform hand hygiene before entering and exiting every room to prevent the potential for the spread of infection. RN-A stated transferring a resident on EBP to bed from a wheelchair would require staff to wear a gown. On 3/25/25 at 1:00 p.m., during an interview the infection preventionist (IP) stated she expected staff to perform hand hygiene when staff entered and exited a room and to wear the appropriate PPE when transferring a resident on EBP. On 3/25/25 at 2:35 p.m., during an interview the director of nursing (DON) stated the expectation was staff would always wash or sanitize their hands before entering and exiting any resident room. The DON stated he expected, when residents were on EBP, staff would follow the instructions on the signs on the door, and follow the education provided recently about EBP. The Hand Hygiene policy revised 7/3/24, indicated it was the policy of Cassia that handwashing/alcohol based hand sanitizer be regarded as the single most important means of preventing the spread of microorganisms/transmission of infection. The policy indicated hand washing/sanitizing was	F 880		

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	245520	A. BUILDING _____ B. WING _____	C 03/25/2025

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

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F 880	Continued From page 7 necessary to prevent health care associated infections and promote health and safety including: before and after providing care to the a resident, before and between passing meal trays, after removing gloves, after touching environmental surfaces near residents, after handling catheters, and after removing PPE. The Personal Protective Equipment policy revised 7/3/24, indicated employees required to perform tasks that may involve exposure to blood/body fluids would be provided appropriate protective clothing and equipment.	F 880		

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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 3/25/25, 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 order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed: H55201881C (MN111662) with a licensing order issued at 1390. 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 not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 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		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.	21390		4/18/25

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21390	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene was completed for 3 of 4 residents (R4, R5, R6). In addition, the facility failed to ensure proper personal protective equipment (PPE) was properly utilized for 1 of 4 resident (R4) reviewed for infection control. Findings include: R4 R4's admission Minimum Data Set (MDS) dated 2/24/25 indicated R4 was cognitively intact, had an indwelling catheter, and was dependent upon staff assistance for transfers. R4's Face Sheet printed 3/25/25, indicated diagnoses included pressure ulcer of sacrum and left thigh, and neuromuscular dysfunction of bladder. R4's care plan dated 2//21/25, indicated an indwelling catheter, and on 3/13/25, indicated enhanced barrier precautions (EBP) (measures intended to prevent the spread of multi-drug resistant organisms) related to a pressure ulcer. On 3/25/25 at 10:52 a.m., during an observation, there were two signs on R4's door that indicated the following: Enhanced Barrier Precautions (EBP) Sign 1: Families and Visitors, please follow enhanced barrier precautions. If you have questions, please see nurse. Everyone must clean their hands before entering room and when leaving the room. Providers and Staff please see reverse side for additional precautions required	21390	Corrected.	

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21390	Continued From page 4 for this room. Sign 2: Providers and Staff: Wear gloves and a gown for the following high-contact resident care activities: Bathing/ showering, transferring residents from one position to another, changing bed linens, providing hygiene (only during high contact activities such as peri-care), changing briefs or assisting with toileting, caring for assisting with an indwelling medical device (for example central venous catheter, urinary catheter, feeding tube care, tracheostomy/ventilator care) and performing wound care. Put on in this order: Perform hand hygiene, gown, mask if needed or mask/eye shield if needed, gloves (if needed) Take OFF & dispose in this order: Gloves, mask/eye shield (if used), gown, mask(if used), perform hand hygiene (even if gloves used). On 3/25/25 at 11:18 a.m., during an observation nursing assistant (NA)-A entered R4's room, performed hand hygiene with alcohol based hand sanitizer (ABHS) , donned gloves and a gown, and entered R4's room. NA-A was already wearing a surgical mask. On 3/25/25 at 11:44 a.m., NA-A left R4's room, still wearing her mask, and used ABHS. On 3/25/25 at 11:45 a.m., during an interview, NA-A confirmed she wore the same mask all day. R5 R5's admission MDS dated 11/16/24, indicated R4 was cognitively intact, had an ostomy (an opening in the abdomen to allow waste to leave	21390		

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21390	Continued From page 5 the body), and kidney insufficiency. R5's Face Sheet printed 3/25/25, indicated diagnoses that included an encounter for artificial opening of the urinary tract - ostomy, and cancer of the posterior wall of bladder. R5's care plan dated 11/12/24, indicated R5 was admitted to the facility for care after surgery on the nervous system, on 11/15/24 had a urostomy related to cancer on wall of the bladder, and on 3/13/25, was on EBP related to the ostomy. On 3/25/25 at 11:01 a.m., during an observation EBP precautions signs were noted on R5's door. Physical therapist (PT)-A pushed R5 in a wheelchair into R5's room, without performing hand hygiene. In addition, PT-A did not don PPE prior to entry to the room. PT-A donned gloves in the room and assisted R5 to transfer into bed. PT-A left the room without performing hand hygiene. PT-A did not wear a gown during the transfer. On 3/25/25 at 11:56 a.m., during an interview PT-A acknowledged he had not performed hand hygiene nor donned a gown prior to entering R5's room. PT-A confirmed he had not performed hand hygiene when he left the room and stated he should have due to EBP in place, and to prevent the potential spread of infection. R6 R6's quarterly MDS dated 2/26/25, indicated R6 was cognitively intact, had an indwelling catheter, a neurogenic bladder (a condition that occurs when the nervous system's connection to the bladder is disrupted, causing bladder control issues), and quadriplegia.	21390		

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21390	Continued From page 6 R6's Face sheet printed 3/25/25, indicated R6 had a pressure ulcer on the right buttock, neuromuscular dysfunction of bladder, and a urogenital (organs and functions related to both the urinary and reproductive systems) implant. R6's care plan dated 4/8/24, identified EBP were in place related to a suprapubic catheter and a wound. On 3/25/25 at 12:19 p.m., during an observation EBP signs were noted on R6's door. NA-B was observed to be passing meal trays from a cart in the hallway. NA-B picked up the meal tray prior to performing hand hygiene, entered R6's room, set the meal tray on R6's bedside table, and rearranged the items on the bedside table to make room for the meal tray. NA-B did not perform hand hygiene when she left the room. On 3/25/25 at 12:20 p.m., during an interview NA-B stated she washed her hands when she left the kitchen, and because she was not performing direct care, she did not need to worry about hand hygiene before or after she left the room. NA-B stated she had training about hand hygiene a week or two ago, was taught to read the signs on the door prior to entering the rooms, and acknowledged she had not. On 3/25/25 at 3:27 p.m., registered nurse (RN)-A stated EBP was for residents with "tubes and wounds" however, staff should perform hand hygiene before entering and exiting every room to prevent the potential for the spread of infection. RN-A stated transferring a resident on EBP to bed from a wheelchair would require staff to wear a gown.	21390		

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21390	Continued From page 7 On 3/25/25 at 1:00 p.m., during an interview the infection preventionist (IP) stated she expected staff to perform hand hygiene when staff entered and exited a room and to wear the appropriate PPE when transferring a resident on EBP. On 3/25/25 at 2:35 p.m., during an interview the director of nursing (DON) stated the expectation was staff would always wash or sanitize their hands before entering and exiting any resident room. The DON stated he expected, when residents were on EBP, staff would follow the instructions on the signs on the door, and follow the education provided recently about EBP. The Hand Hygiene policy revised 7/3/24, indicated it was the policy of Cassia that handwashing/alcohol based hand sanitizer be regarded as the single most important means of preventing the spread of microorganisms/transmission of infection. The policy indicated hand washing/sanitizing was necessary to prevent health care associated infections and promote health and safety including: before and after providing care to the a resident, before and between passing meal trays, after removing gloves, after touching environmental surfaces near residents, after handling catheters, and after removing PPE. The Personal Protective Equipment policy revised 7/3/24, indicated employees required to perform tasks that may involve exposure to blood/body fluids would be provided appropriate protective clothing and equipment. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee could re-educate staff on appropriate Infection Control practices for Standard and Enhanced Barrier	21390		

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21390	Continued From page 8 Precautions (EBP) to ensure proper hand hygiene and acceptable donning/doffing of personal protective equipment (PPE). The DON or designee could perform periodic audits to ensure staff adherence, results of those audits could be taken to the Quality Assurance and Performance Improvement (QAPI) committeeto determine compliance and need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		