Electronically Submitted
November 16, 2021

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

RE: CCN: 245520
Cycle Start Date: October 28, 2021

Dear Administrator:

On October 28, 2021, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On October 28, 2021, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 1, 2021.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 1, 2021, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 1, 2021, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 28, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.</u>

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Redeemer Residence Inc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 28, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 28, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40,

et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132

Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	C 10/28/2021

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 10/26/21, through 10/28/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5520092C (MN77856, MN77929) with deficiencies cited at F600, F745, and F558. H5520093C (MN77857) with deficiencies cited at F600 and F745. The survey resulted in an Immediate Jeopardy (IJ) at F600 when the facility was notified NA-A had engaged in sexual activity with R1. The facility initiated an investigation including resident interviews, and during these interviews, R2 stated she had been sexually abused by NA-A. The IJ began on 10/20/21, and the immediacy was removed on 10/28/21, at 1:28 p.m. The above findings constituted substandard quality of care, and an extended survey was conducted on 10/28/21. 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	F 000		

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

Electronically Signed | 11/24/2021

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

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F 000	Continued From page 1 regulations has been attained.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a call light was accessible for 1 of 3 resident (R3) who was dependent upon staff for assistance. Findings include: R3's Face Sheet printed 10/28/21, indicated R3's diagnosis included vascular dementia with behavioral disturbance, fracture of left radius (arm), and repeated falls. R3's significant change Minimum Data Set (MDS) dated 7/21/21, indicated R3 had a significant cognitive impairment, required extensive assistance with bed mobility, transfers, and locomotion. R3 was "not steady" when moving from seated to standing position, walking, turning, or transferring. R3 utilized a walker and wheelchair for locomotion. R3's Care Area Assessment (CAA) for falls dated 7/22/21, indicated R3 was at risk for falls due to impaired balance, current diagnosis and medications, decline in functional status, incontinence, muscle weakness, visual	F 558	This Plan of Correction constitutes the facility□s written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of the facility to have call lights in reach for each dependent residents at all times. Regarding cited resident: Regarding R3, call light was placed within reach immediately after staff notified by surveyor. Measures put in place to ensure deficient practice does not recur: All appropriate staff were re-educated on appropriate call light placement. Effective implementation of actions will be monitored by:	11/26/21

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F 558	Continued From page 2 impairment, hearing impairment, and cognitive impairment. R3 required care planned interventions to manage risk factors. R3's care plan dated 5/13/21, indicated R3 was at risk for falls due to history of falling, instability with balance and gait, and current diagnosis. R3's care plan lacked indication to ensure the call light was within reach. On 7/16/21, at 12:06 a.m. a progress note indicated R3 self-transferred daily and ambulated by herself. R3 required reminders to use her call light for assistance with walking, and staff were to anticipate R3's needs. On 8/5/21, at 10:01 a.m. a progress note indicated R3's safety was managed by placing R3 near the nurse's station. On 10/26/21, at 9:50 a.m. R3 was observed lying in bed. R3's call light was hanging out of reach on the wall behind her bed. R3 began calling out, "I am going to die" and "Help me." At 9:53 a.m. nursing assistant (NA)-A entered R3's room and stated, "She's always like that," and took R3's meal tray. When asked where R3's call light was, NA-A stated, "Yeah, where is her call light?" NA-A verified R3's call light was hanging on the wall behind R3, and stated she was unsure why the call light was not within R3's reach. NA-A handed the call light to R3, who demonstrated the ability to use the call light. On 10/27/21, at approximately 1:00 p.m. the director of nursing (DON) was interviewed. The DON stated call lights should be within reach for all residents. The DON stated she believed R3 was a fall risk, and could use the call light.	F 558	Audits of appropriate call light placement will be done 3 times per week x 1 month, 2 times per week for 1 month, and then 1 time per week for 1 month to ensure appropriate call light placement. Results of these audits will be reviewed by the facility QAPI committee who will determine if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Director of Nursing or designee is responsible for maintaining compliance. Completion date for certification purposes only is:	

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F 558	Continued From page 3 The facility policy Fall Assessment and Managing Fall Risk reviewed 11/14/19, directed standard fall reduction interventions for all residents included call lights placed in reach and accessible to resident when resident is in their room.	F 558		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free from sexual abuse for 2 of 3 residents (R1, R2) reviewed for sexual abuse allegations. Nursing assistant (NA)-A engaged in sexual activity with R1 and R2. This resulted in an immediate jeopardy (IJ) for R1 and R2, who were sexually abused and sustained psychosocial harm by NA-A. The immediate jeopardy began on 10/20/21,	F 600	It is the policy and practice of the facility that all residents are provided a safe environment free from any form of abuse. Education is provided to all staff, at minimum on an annual basis, regarding all aspects of abuse and abuse reporting. Prior to these 2 incidents, all staff had been education on the facility□s abuse prevention practices. Each employee also undergoes a criminal background check prior to employment.	11/26/21

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F 600	Continued From page 4 when the facility was notified NA-A had engaged in sexual activity with R1. The facility initiated an investigation including resident interviews, and during these interviews, R2 stated she had been sexually abused by NA-A. The administrator, director of nursing (DON), and the director of social services (SS)-A were notified of the immediate jeopardy at 1:38 p.m. on 10/27/21. The IJ was removed on 10/28/21, at 1:28 p.m. but non-compliance remained at the lower scope and severity of D, isolated, no actual harm, with potential for more than minimal harm. Findings include: R1's Face Sheet printed 10/28/21, indicated R1 was admitted to the facility with diagnoses that included sequelae of cerebral infarction (residual effects of a stroke), mild cognitive impairment, anxiety disorder, and adult failure to thrive. R1's significant change in status Minimum Date Set (MDS) dated 9/24/21, indicated R1 had a moderate cognitive impairment, and required extensive assistance with bed mobility, dressing, toilet use, and personal hygiene. R1's care plan dated 9/9/21, indicated R1 had no known history of abuse or neglect, and was at risk for abuse/neglect due to vulnerable status living in a skilled nursing facility (SNF). The care plan indicated R1 would remain safe and free from abuse. R1's Abuse Assessment dated 9/10/21, indicated R1 had no history of abuse, but was at risk for abuse by others due to physical limitations including weakness and impaired mobility.	F 600	Regarding cited resident: Regarding the incidents related to R1 and R2, all aspects of mandated reporting were completed. Immediately upon being notified of the incidents on 10/20/21, reports were filed with the police and the state agency and NA-A was suspended. In addition, staff were re-educated on vulnerable adult policy and procedure beginning on 10/20/2021, all residents on the specific unit were interviewed for any suspected abuse-to which none were reported. These actions took place prior to the investigation. During the investigation, NA-A was terminated on 10/21/21, new abuse risk observations were completed for R1 and R2 and care plans were updated on 10/26/2021. R1 discharged from the facility on 11/19/2021. Measures put in place to ensure deficient practice does not recur: Staff were re-educated on vulnerable adult policy and procedure beginning on 10/20/2021. All interview-able residents were interviewed regarding vulnerable adult issues with no further concerns noted. New abuse risk observations were completed for all other residents on 10/26/2021. Abuse and vulnerable adult education will continue to be provided upon hire, annually, and as needed. Effective implementation of actions will be monitored by: Audits of staff knowledge of vulnerable adult policy coupled with resident	

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F 600	Continued From page 5 A Facility Reported Incident dated 10/20/21, at 3:18 p.m. indicated R1 reported to family member (FM)-A that nursing assistant (NA)-A came into her room at night and fondled her breasts. FM-A reported this to the facility on 10/20/21, at approximately 1:30 p.m. The police were called, NA-A was suspended, and an internal investigation began. R1 identified NA-A through a series of staff photos presented to her. On 10/26/21, at 11:40 a.m. R1 was interviewed. R1 stated shortly after she moved into the facility in September, NA-A began making comments such as R1 "had a nice body" whenever he worked with her. R1 stated this made her "really uncomfortable." R1 stated on 4 to 5 occasions, NA-A touched her breasts, and placed his penis into R1's hand until NA-A "got his job done." R1 stated NA-A would also conduct this behavior in the bathroom while he toileted R1. R1 stated this made her feel "really sad," "dumb," "terrible," and "so abused." R1 stated she would prefer female caregivers apart from one male NA that she did like working with. R1 stated she had not been offered psychiatry or other mental health services but felt it would "probably" help her to talk about it. On 10/26/21, at 1:30 p.m. family member (FM)-A stated R1 began reporting to her someone was touching and squeezing her breasts right after she was admitted to the facility. FM-A believed R1 was referring to being showered, and thought R1 was uncomfortable with the new facility or with male staff. FM-A stated a few weeks later R1 mentioned the touching again, but she was unsure what to do. FM-A stated on 10/20/21, she assisted R1 to the bathroom and R1 told her she was getting tired of the "invasiveness" of the staff,	F 600	questionnaires regarding potential abuse will be done 3 times per week x 1 month, 2 times per week for 1 month, and then 1 time per week for 1 month. Results of these audits will be reviewed by the facility QAPI committee who will determine if further monitoring/audits are recommended. In addition, quarterly care conferences will include residents being asked if any abuse has occurred. Those responsible to maintain compliance will be: The Director of Nursing or designee is responsible for maintaining compliance. Completion date for certification purposes only is: 11/26/2021	

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	245520	A. BUILDING _____ B. WING _____	C 10/28/2021

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

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F 600	Continued From page 6	F 600		

and told her NA-A touched and squeezed her breasts, lingered near her vagina during cares, and now was making her touch his penis. R1 told FM-A NA-A started having R1 touch his penis while she was lying in bed, and then would take her into the bathroom and do the same thing. R1 told FM-A this occurred "almost every night."
FM-A stated R1 was "super scared" at night, and did not know what to do. FM-A stated she reported this to social service (SS)-A around 2:00 p.m., and the facility initiated an investigation.
FM-A stated on 10/20/21, at about 4:30 p.m. SS-A called and stated a second resident alleged abuse from NA-A. FM-A stated the DON followed-up with her today, and told her NA-A had been fired.

On 10/26/21, at 3:12 p.m. SS-A was interviewed and stated she received the report of R1's alleged abuse from FM-A on the afternoon of 10/20/21. SS-A stated she notified the DON, an investigation was initiated, a report as filed, and the police were notified. SS-A stated R1, FM-A, the DON, and herself had discussed R1's preference for female care givers and staff performing overnight checks to see how R1 was doing, however, R1's care plan had not been updated to reflect these interventions. SS-A stated R1 would require an updated abuse assessment, which was completed upon admission, annually, or as needed, and this had not yet been completed.

On 10/26/21, at 2:48 p.m. a progress note indicated R1's nurse practitioner (NP)-A was updated regarding the "incident."
On 10/26/21, at 4:41 p.m. NP-A was interviewed and stated she had not been made aware of R1's allegations until moments ago when she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600	Continued From page 7	F 600		

contacted and updated by the DON.

R2's Face Sheet printed 10/28/21, indicated R2 was admitted to the facility with diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side, major depressive disorder, adjustment disorder with anxiety, and cognitive communication deficit.

R2's admission MDS dated 9/26/21, indicated R2 was cognitively intact, and required extensive assistance with bed mobility, locomotion, dressing, and toilet use.

R2's care plan dated 9/21/21, indicated R2 was at risk for abuse or neglect due to vulnerable status living in SNF. The care plan indicated R2 would remain safe and free from abuse.

R2's Abuse Assessment dated 9/21/21, indicated R2 had a history of self-abuse and being abused by others. R2 was at risk for abuse by others due to physical limitations.

A Facility Reported Incident dated 10/20/21, at 4:10 p.m. indicated R2 reported NA-A fondled both of her breasts, and kissed her on the cheek. R2 identified NA-A through a series of staff photos presented to her.

On 10/26/21, at 1:13 p.m. a progress note indicated SS-A met with R2 to provide psychosocial support regarding the incident of trauma. R2 reported to SS-A she was still having nightmares of what NA-A did to her. SS-A informed R2 that NA-A no longer worked at the

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F 600	Continued From page 8	F 600		

facility, and was not allowed in the building. R2 stated she was glad, and she felt much better that NA-A would not come into her room again at night.

On 10/27/21, at 12:14 p.m. a progress note indicated R2 told SS-A she had slept better last night with no nightmares.

On 10/26/21, at 2:14 p.m. R2 was interviewed. R2 stated NA-A began touching her breasts a few weeks ago during the overnight shift when he assisted her in the bathroom. R2 stated this occurred on 4 to 5 occasions, she knew it was not accidental, but she was too scared to say anything. R2 stated NA-A was a "really big man." R2 stated NA-A made her lay in bed with her privates exposed like a "baby" to change her "diaper" which no other staff did. R2 stated she used a pull-up incontinent product, which was changed in the bathroom during toileting. R2 stated on another occasion, NA-A stroked her head, kissed her on the cheek, and stated he liked her because she did not complain or shout like the other residents. R2 stated once she realized NA-A was intentionally touching her breasts, she stopped using her call light even if she needed to be toileted or changed, because she was afraid of NA-A. R2 stated she has had "a lot of nightmares about it." R2 stated she had told SS-A she was still scared of NA-A and had a great fear NA-A would come find her. R2 stated she would prefer female caregivers except one male NA that she did like working with. R2 stated she was not offered only women, and believe it was "mandatory" you must settle for whichever staff you were given. R2 stated lately if she woke up in the night, she could not fall back asleep "because I remember everything."

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F 600	Continued From page 9	F 600		

On 10/26/21, at 4:31 p.m. NP-B stated she was not informed of R2's sexual abuse allegations. NP-B was unaware R2 had difficulty sleeping.

On 10/26/21, at approximately 3:00 p.m. the DON was interviewed, and stated she believed the sexual abuse had occurred, and NA-A had been fired. The DON stated NA-A had three prior allegations of sexual abuse against residents, however, those residents had later recanted their statements. These allegations were on 7/1/16, 12/7/17, and 7/16/18. The DON stated there was an allegation of physical abuse allegation against NA-A on 2/9/20, but was investigated and found unsubstantiated.

On 10/26/21, at 3:12 p.m. SS-A was interviewed. SS-A stated she received the report of R2's abuse on the afternoon of 10/20/21, during the investigation of R1's allegation. SS-A stated during the investigation, R2 stated NA-A had sexually touched her just the prior overnight shift from 10/19/21, through 10/20/21. SS-A stated R2 had told her she had nightmares about the incident, and was having trouble falling back asleep. SS-A stated she had assured R2 that NA-A was no longer working at the facility. SS-A stated R2 would require an updated abuse assessment, which was completed upon admission, annually, or as needed, and this had not yet been completed.

On 10/27/21, at 10:36 a.m. the medical director (MD)-A was interviewed. MD-A stated he had not been made aware of the abuse allegations until yesterday afternoon 10/26/21, when the DON notified him. MD-A stated he asked the DON if there had been previous incidents or accusations

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 10/28/2021

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F 600	Continued From page 10	F 600		

with NA-A and the DON stated she could not recall. MD-A stated the DON had told stated NA-A was "not on their radar." MD-A stated there could be a "significant impact" on residents and families because of this incident. MD stated preexisting mental health diagnosis such as depression or anxiety could be exacerbated, and impacted residents would probably need counseling within a week or so of the incidents.

On 10/27/21, at 9:43 a.m. law enforcement (LE)-A was interviewed. LE-A stated they interviewed NA-A, and he had denied all allegations. LE-A stated they interviewed R1 and R2, and both were consistent with maintaining they were touched by NA-A. LE-A stated R1 told him she was touched under her clothing not more than five times and had skin to skin touching of NA-A's penis. LE-A stated R2 told him she was touched over her clothing five times. LE-A stated both R1 and R2 stated they had fear and discomfort regarding the abuse.

On 10/27/21, at 11:55 a.m. NA-A was interviewed. NA-A stated he had worked with R1 and R2 on the overnight shift. NA-A stated he had assisted both R1 and R2 with personal cares including toileting. NA-A stated he had been made aware of the sexual abuse allegations by law enforcement and stated, "I did not do that."

The facility policy Vulnerable adult-MN revised 10/31/19, defined sexual abuse as non-consensual sexual contact of any type with a resident. The policy defined exploitation as taking advantage of a resident for personal gain using manipulation, intimidation, threat, or coercion. When required, the resident physician is notified and informed of the progress of the investigation.

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	245520	A. BUILDING _____ B. WING _____	C 10/28/2021

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F 600	Continued From page 11 The IJ which began on 10/20/21, was removed on 10/28/21, when the facility successfully implemented a removal plan which included: termination of NA-A, filing of a police report, updating R1 and R2's care plans to include trauma interventions. All cognitively intact and interviewable residents (103/111) were interviewed on 10/26/21, with no additional reports of abuse or neglect. Updated abuse assessments were completed for all 111 residents in the facility. Vulnerable Adult policy reviewed, and education of facility staff was provided on the facility's abuse prevention policy. This was verified on 10/28/21, with interviews with staff verifying training on abuse. Interviews with residents and record review verified the facility reassessed all residents residing in the facility to determine their risk for abuse and identify any other potential residents affected.	F 600		
F 745 SS=G	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to address psychosocial needs after trauma of sexual abuse by a staff person for 2 of 3 residents (R1, R2) reviewed for psychosocial services. This resulted in actual psychological harm for R1 and R2, who expressed on-going feelings of guilt and fear, and nightmares with difficulty sleeping related to their sexual abuse.	F 745	F745 It is the policy and practice of the facility to address psychosocial needs of all residents. Regarding cited residents: Both R1 and R2 were offered and accepted in house psychology services on 10/26/2021 and were seen by MSW,	11/26/21

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 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 745	Continued From page 12 Findings include: R1's Face Sheet printed 10/28/21, indicated R1 was admitted to the facility with diagnosis that included sequelae of cerebral infarction (residual effects of a stroke), cognitive impairment, anxiety disorder, and adult failure to thrive. R1's significant change in status Minimum Data Set (MDS) dated 9/24/21, indicated R1 had a moderate cognitive impairment, and had no mood or behavioral concerns. R1's care plan dated 9/9/21, indicated R1 had no known history of abuse or neglect. R1 was at risk for abuse/neglect due to vulnerable status living in a skilled nursing facility (SNF) and would remain safe and free from abuse. R1's Patient Health Questionnaire (PHQ-9, a depression screening) dated 9/9/21, indicated R1 had minimal depression. R1's Abuse Assessment dated 9/10/21, indicated R1 had no history of abuse, but was at risk for abuse by others due to physical limitations including weakness and impaired mobility. A Facility Reported Incident dated 10/20/21, at 3:18 p.m. indicated R1 reported to family member (FM)-A that nursing assistant (NA)-A came into her room at night and fondled her breasts. FM-A reported this to the facility on 10/20/21, at approximately 1:30 p.m. The police were called, NA-A was suspended, and an internal investigation began. R1 identified NA-A through a series of staff photos presented to her. On 10/22/21, at 5:04 p.m. a progress note	F 745	LICSW on 10/27/2021. Director of social services and nursing staff have visited R1 and R2 weekly since 10/26/2021 for wellness checks. R1 discharged from facility on 11/19/2021. Measures put in place to ensure deficient practice does not recur: Social services were re-educated on offering and documenting psychosocial support immediately and offering outside psychology services as needed after an allegation of abuse. Effective implementation of actions will be monitored by: Audits of psychosocial support implementation following any allegations of abuse will occur 3 times per week x 1 month, 2 times per week for 1 month, and then 1 time per week for 1 month. Results of these audits will be reviewed by the facility QAPI committee who will determine if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Director of Social Services or designee is responsible for maintaining compliance. Completion date for certification purposes only is:	

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F 745	Continued From page 13	F 745		

indicated R1 remained "reclusive," would only speak with visitors and certain staff, and would not verbalize her needs often.

On 10/26/21, at 2:48 p.m. a progress note indicated R1's nurse practitioner (NP)-A was updated regarding the sexual abuse.

On 10/26/21, at 11:40 a.m. R1 was interviewed. R1 stated shortly after she moved into the facility in September, NA-A began making comments such as R1 "had a nice body" whenever he worked with her. R1 stated this made her "really uncomfortable." R1 stated on 4 to 5 occasions, NA-A touched her breasts, and placed his penis into R1's hand until NA-A "got his job done." R1 stated NA-A would also conduct this behavior in the bathroom while he toileted R1. R1 stated this made her feel "really sad," "dumb," "terrible," and "so abused." R1 stated she would prefer female caregivers apart from one male NA that she did like working with. R1 stated she had not been offered psychiatry or other mental health services but felt it would "probably" help her to talk about it.

On 10/26/21, at 1:30 p.m. family member (FM)-A stated R1 began reporting to her someone was touching and squeezing her breasts right after she was admitted to the facility. FM-A believed R1 was referring to being showered, and thought R1 was uncomfortable with the new facility or with male staff. FM-A stated a few weeks later R1 mentioned the touching again, but she was unsure what to do. FM-A stated on 10/20/21, she assisted R1 to the bathroom and R1 told her she was getting tired of the "invasiveness" of the staff, and told her NA-A touched and squeezed her breasts, lingered near her vagina during cares, and now was making her touch his penis. R1 told

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 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 745	Continued From page 14	F 745		

FM-A NA-A started having R1 touch his penis while she was lying in bed, and then would take her into the bathroom and do the same thing. R1 told FM-A this occurred "almost every night." FM-A stated R1 was "super scared" at night, and did not know what to do. FM-A stated she was not contacted to follow up about the incident until today by the DON who asked FM-A if R1 would like therapy. FM-A stated R1 should have therapy as she felt R1 was "very traumatized," was not sleeping well due to on-going fear of NA-A, and was "humiliated."

On 10/26/21, at 3:12 p.m. SS-A was interviewed and stated she had not yet asked R1 if she would like mental health services.

On 10/26/21, at 4:41 p.m. nurse practitioner (NP)-A was interviewed and stated she had not been made aware of R1's allegations until moments ago when she was contacted and updated by the DON.

R1's psychology note dated 10/28/21, indicated new diagnoses of adjustment disorder with mixed anxiety and depressed mood. R1 had some emotional distress affecting overall wellbeing. R1 reported she had not slept well in the recent weeks. R1 stated she felt "guilty" for reporting the abuse and felt "embarrassed" that staff were talking about it.

R2's Face Sheet printed 10/28/21, indicated R2 was admitted to the facility with diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side, major depressive disorder, adjustment disorder with

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F 745	Continued From page 15	F 745		

anxiety, and cognitive communication deficit.

R2's admission MDS dated 9/26/21, indicated R2 was cognitively intact and required extensive one person assistance with bed mobility, locomotion, dressing, and toilet use. R2 had a depressed mood with no behavioral symptoms noted.

R2's care plan dated 9/21/21, indicated R2 had a history of abuse or neglect, and was at risk for abuse or neglect due to vulnerable status living in SNF. The care plan indicated R2 would remain safe and free from abuse.

R2's PHQ-9 dated 9/21/21, indicated a score of 16 meaning moderately severe depression.

R2's Abuse Assessment dated 9/21/21, indicated R2 had a history of self-abuse and being abused by others. R2 was at risk for abuse by others due to physical limitations.

On 10/24/21, at 3:55 p.m. a progress note indicated R2 admitted she was overeating at night.

On 10/26/21, at 1:13 p.m. a progress note indicated SS-A met with R2 to provide psychosocial support regarding the incident of trauma. R2 reported to SS-A she was still having nightmares of what NA-A did to her. SS-A informed R2 that NA-A no longer worked at the facility, and was not allowed in the building. R2 stated she was glad, and she felt much better NA-A would not come into her room again at night.

On 10/26/21, at 2:14 p.m. R2 was interviewed. R2 stated NA-A began touching her breasts a few

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F 745	Continued From page 16	F 745		

weeks ago during the overnight shift when he assisted her in the bathroom. R2 stated this occurred on 4 to 5 occasions, she knew it was not accidental, but she was too scared to say anything. R2 stated NA-A was a "really big man." R2 stated NA-A made her lay in bed with her privates exposed like a "baby" to change her "diaper" which no other staff did. R2 stated she used a pull-up incontinent product, which was changed in the bathroom during toileting. R2 stated on another occasion, NA-A stroked her head, kissed her on the cheek, and stated he liked her because she did not complain or shout like the other residents. R2 stated once she realized NA-A was intentionally touching her breasts, she stopped using her call light even if she needed to be toileted or changed, because she was afraid of NA-A. R2 stated she has had "a lot of nightmares about it." R2 stated she had told SS-A she was still scared of NA-A and had a great fear NA-A would come find her. R2 stated she would prefer female caregivers apart from one male NA that she did like working with. R2 stated she was not offered only women, and believe it was "mandatory" you must settle for whichever staff you were given. R2 stated lately if she woke up in the night, she could not fall back asleep "because I remember everything." R2 stated she had not been offered a follow up psychiatry appointment or other mental health services.

On 10/26/21, at 3:48 p.m. a progress note indicated R2 would be offered in-house psychologist.

On 10/27/21, at 12:14 p.m. a progress note indicated R2 stated she had slept better last night with no nightmares. Psychologist would see R2

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	245520	A. BUILDING _____ B. WING _____	C 10/28/2021

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

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F 745	Continued From page 17	F 745		

today, and weekly visits were recommended.

R2's psychology note dated 10/28/21, indicated R2 had moderate emotional distress affecting her overall wellbeing. R2 reported her sleep had been impaired.

On 10/26/21, at 4:31 p.m. NP-B was interviewed and stated she was not informed of R2's sexual abuse allegations. NP-B stated she was not aware of R2's difficulty sleeping.

When interviewed on 10/26/21, at approximately 3:00 p.m. the DON was interviewed, and stated she believed the sexual abuse had occurred, and NA-A had been fired.

On 10/26/21, at 3:12 p.m. SS-A was interviewed. SS-A stated she received the report of R2's abuse on the afternoon of 10/20/21, during the investigation of R1's allegation. SS-A stated during the investigation, R2 stated NA-A had sexually touched her just the prior overnight shift from 10/19/21, through 10/20/21. SS-A stated R2 had told her she had nightmares about the incident, and was having trouble falling back asleep. SS-A stated she had assured R2 that NA-A was no longer working at the facility. SS-A stated R2 would receive psych services this week.

On 10/27/21, at 10:36 a.m. the medical director (MD)-A was interviewed. MD-A stated he had not been made aware of the abuse allegations until yesterday afternoon 10/26/21, when the DON notified him. MD-A stated there could be a "significant impact" on residents and families because of this incident. MD stated preexisting mental health diagnosis such as depression or

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F 745	Continued From page 18 anxiety could be exacerbated, and impacted residents would probably need counseling within a week or so of the incidents. The facility policy Vulnerable adult-MN revised 10/31/19, defined sexual abuse as non-consensual sexual contact of any type with a resident. the policy defined mental abuse had the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation.	F 745		

Electronically delivered
November 16, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: 40JG11

Dear Administrator:

The above facility was surveyed on October 26, 2021 through October 28, 2021 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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit

Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 10/26/21, through 10/28/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date	2 000		

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2 000	Continued From page 1 when they will be completed. The following complaints were found to be SUBSTANTIATED: H5520092C (MN77856, MN77929) with licensing orders issued at 4568.0560 and 144.651 Subd G. H5520093C (MN77857) with licensing orders issued at 4568.0560. 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	2 000		

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2 000	Continued From page 2 is enrolled in ePOC and therefore a signature is 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 interview and document review, the facility failed to address psychosocial needs after trauma of sexual abuse by a staff person for 2 of 3 residents (R1, R2) reviewed for psychosocial services. This resulted in actual psychological harm for R1 and R2, who expressed on-going feelings of guilt and fear, and nightmares with difficulty sleeping related to their sexual abuse. Findings include: R1's Face Sheet printed 10/28/21, indicated R1 was admitted to the facility with diagnosis that included sequelae of cerebral infarction (residual	21475	Corrected	11/26/21

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21475	Continued From page 3	21475		

effects of a stroke), cognitive impairment, anxiety disorder, and adult failure to thrive.

R1's significant change in status Minimum Data Set (MDS) dated 9/24/21, indicated R1 had a moderate cognitive impairment, and had no mood or behavioral concerns.

R1's care plan dated 9/9/21, indicated R1 had no known history of abuse or neglect. R1 was at risk for abuse/neglect due to vulnerable status living in a skilled nursing facility (SNF) and would remain safe and free from abuse.

R1's Patient Health Questionnaire (PHQ-9, a depression screening) dated 9/9/21, indicated R1 had minimal depression.

R1's Abuse Assessment dated 9/10/21, indicated R1 had no history of abuse, but was at risk for abuse by others due to physical limitations including weakness and impaired mobility.

A Facility Reported Incident dated 10/20/21, at 3:18 p.m. indicated R1 reported to family member (FM)-A that nursing assistant (NA)-A came into her room at night and fondled her breasts. FM-A reported this to the facility on 10/20/21, at approximately 1:30 p.m. The police were called, NA-A was suspended, and an internal investigation began. R1 identified NA-A through a series of staff photos presented to her.

On 10/22/21, at 5:04 p.m. a progress note indicated R1 remained "reclusive," would only speak with visitors and certain staff, and would not verbalize her needs often.

On 10/26/21, at 2:48 p.m. a progress note indicated R1's nurse practitioner (NP)-A was

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21475	Continued From page 4 updated regarding the sexual abuse. On 10/26/21, at 11:40 a.m. R1 was interviewed. R1 stated shortly after she moved into the facility in September, NA-A began making comments such as R1 "had a nice body" whenever he worked with her. R1 stated this made her "really uncomfortable." R1 stated on 4 to 5 occasions, NA-A touched her breasts, and placed his penis into R1's hand until NA-A "got his job done." R1 stated NA-A would also conduct this behavior in the bathroom while he toileted R1. R1 stated this made her feel "really sad," "dumb," "terrible," and "so abused." R1 stated she would prefer female caregivers apart from one male NA that she did like working with. R1 stated she had not been offered psychiatry or other mental health services but felt it would "probably" help her to talk about it. On 10/26/21, at 1:30 p.m. family member (FM)-A stated R1 began reporting to her someone was touching and squeezing her breasts right after she was admitted to the facility. FM-A believed R1 was referring to being showered, and thought R1 was uncomfortable with the new facility or with male staff. FM-A stated a few weeks later R1 mentioned the touching again, but she was unsure what to do. FM-A stated on 10/20/21, she assisted R1 to the bathroom and R1 told her she was getting tired of the "invasiveness" of the staff, and told her NA-A touched and squeezed her breasts, lingered near her vagina during cares, and now was making her touch his penis. R1 told FM-A NA-A started having R1 touch his penis while she was lying in bed, and then would take her into the bathroom and do the same thing. R1 told FM-A this occurred "almost every night." FM-A stated R1 was "super scared" at night, and did not know what to do. FM-A stated she was not contacted to follow up about the incident until	21475		

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21475	Continued From page 5	21475		

today by the DON who asked FM-A if R1 would like therapy. FM-A stated R1 should have therapy as she felt R1 was "very traumatized," was not sleeping well due to on-going fear of NA-A, and was "humiliated."

On 10/26/21, at 3:12 p.m. SS-A was interviewed and stated she had not yet asked R1 if she would like mental health services.

On 10/26/21, at 4:41 p.m. nurse practitioner (NP)-A was interviewed and stated she had not been made aware of R1's allegations until moments ago when she was contacted and updated by the DON.

R1's psychology note dated 10/28/21, indicated new diagnoses of adjustment disorder with mixed anxiety and depressed mood. R1 had some emotional distress affecting overall wellbeing. R1 reported she had not slept well in the recent weeks. R1 stated she felt "guilty" for reporting the abuse and felt "embarrassed" that staff were talking about it.

R2's Face Sheet printed 10/28/21, indicated R2 was admitted to the facility with diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side, major depressive disorder, adjustment disorder with anxiety, and cognitive communication deficit.

R2's admission MDS dated 9/26/21, indicated R2 was cognitively intact and required extensive one person assistance with bed mobility, locomotion, dressing, and toilet use. R2 had a depressed mood with no behavioral symptoms noted.

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21475	Continued From page 6	21475		

R2's care plan dated 9/21/21, indicated R2 had a history of abuse or neglect, and was at risk for abuse or neglect due to vulnerable status living in SNF. The care plan indicated R2 would remain safe and free from abuse.

R2's PHQ-9 dated 9/21/21, indicated a score of 16 meaning moderately severe depression.

R2's Abuse Assessment dated 9/21/21, indicated R2 had a history of self-abuse and being abused by others. R2 was at risk for abuse by others due to physical limitations.

On 10/24/21, at 3:55 p.m. a progress note indicated R2 admitted she was overeating at night.

On 10/26/21, at 1:13 p.m. a progress note indicated SS-A met with R2 to provide psychosocial support regarding the incident of trauma. R2 reported to SS-A she was still having nightmares of what NA-A did to her. SS-A informed R2 that NA-A no longer worked at the facility, and was not allowed in the building. R2 stated she was glad, and she felt much better NA-A would not come into her room again at night.

On 10/26/21, at 2:14 p.m. R2 was interviewed. R2 stated NA-A began touching her breasts a few weeks ago during the overnight shift when he assisted her in the bathroom. R2 stated this occurred on 4 to 5 occasions, she knew it was not accidental, but she was too scared to say anything. R2 stated NA-A was a "really big man." R2 stated NA-A made her lay in bed with her privates exposed like a "baby" to change her "diaper" which no other staff did. R2 stated she used a pull-up incontinent product, which was

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21475	Continued From page 7	21475		

changed in the bathroom during toileting. R2 stated on another occasion, NA-A stroked her head, kissed her on the cheek, and stated he liked her because she did not complain or shout like the other residents. R2 stated once she realized NA-A was intentionally touching her breasts, she stopped using her call light even if she needed to be toileted or changed, because she was afraid of NA-A. R2 stated she has had "a lot of nightmares about it." R2 stated she had told SS-A she was still scared of NA-A and had a great fear NA-A would come find her. R2 stated she would prefer female caregivers apart from one male NA that she did like working with. R2 stated she was not offered only women, and believe it was "mandatory" you must settle for whichever staff you were given. R2 stated lately if she woke up in the night, she could not fall back asleep "because I remember everything." R2 stated she had not been offered a follow up psychiatry appointment or other mental health services.

On 10/26/21, at 3:48 p.m. a progress note indicated R2 would be offered in-house psychologist.

On 10/27/21, at 12:14 p.m. a progress note indicated R2 stated she had slept better last night with no nightmares. Psychologist would see R2 today, and weekly visits were recommended.

R2's psychology note dated 10/28/21, indicated R2 had moderate emotional distress affecting her overall wellbeing. R2 reported her sleep had been impaired.

On 10/26/21, at 4:31 p.m. NP-B was interviewed and stated she was not informed of R2's sexual abuse allegations. NP-B stated she was not

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21475	Continued From page 8 aware of R2's difficulty sleeping. When interviewed on 10/26/21, at approximately 3:00 p.m. the DON was interviewed, and stated she believed the sexual abuse had occurred, and NA-A had been fired. On 10/26/21, at 3:12 p.m. SS-A was interviewed. SS-A stated she received the report of R2's abuse on the afternoon of 10/20/21, during the investigation of R1's allegation. SS-A stated during the investigation, R2 stated NA-A had sexually touched her just the prior overnight shift from 10/19/21, through 10/20/21. SS-A stated R2 had told her she had nightmares about the incident, and was having trouble falling back asleep. SS-A stated she had assured R2 that NA-A was no longer working at the facility. SS-A stated R2 would receive psych services this week. On 10/27/21, at 10:36 a.m. the medical director (MD)-A was interviewed. MD-A stated he had not been made aware of the abuse allegations until yesterday afternoon 10/26/21, when the DON notified him. MD-A stated there could be a "significant impact" on residents and families because of this incident. MD stated preexisting mental health diagnosis such as depression or anxiety could be exacerbated, and impacted residents would probably need counseling within a week or so of the incidents. The facility policy Vulnerable adult-MN revised 10/31/19, defined sexual abuse as non-consensual sexual contact of any type with a resident. the policy defined mental abuse had the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation.	21475		

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21475	Continued From page 9 SUGGESTED METHOD OF CORRECTION: The social worker or designee, could review and/or revise facility policies and procedures related to medically related social services. Responsible personnel could be re-educated on these policies and procedures. Appropriate efforts could be made toward supporting the social service needs of the individual(s) identified in the deficiency, with supporting documentation maintained. Other residents could be evaluated for social service needs. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21475		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a call light was accessible for 1 of 3 resident (R3) who was	21810	Corrected	11/26/21

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 _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21810	Continued From page 10 dependent upon staff for assistance. Findings include: R3's Face Sheet printed 10/28/21, indicated R3's diagnosis included vascular dementia with behavioral disturbance, fracture of left radius (arm), and repeated falls. R3's significant change Minimum Data Set (MDS) dated 7/21/21, indicated R3 had a significant cognitive impairment, required extensive assistance with bed mobility, transfers, and locomotion. R3 was "not steady" when moving from seated to standing position, walking, turning, or transferring. R3 utilized a walker and wheelchair for locomotion. R3's Care Area Assessment (CAA) for falls dated 7/22/21, indicated R3 was at risk for falls due to impaired balance, current diagnosis and medications, decline in functional status, incontinence, muscle weakness, visual impairment, hearing impairment, and cognitive impairment. R3 required care planned interventions to manage risk factors. R3's care plan dated 5/13/21, indicated R3 was at risk for falls due to history of falling, instability with balance and gait, and current diagnosis. R3's care plan lacked indication to ensure the call light was within reach. On 7/16/21, at 12:06 a.m. a progress note indicated R3 self-transferred daily and ambulated by herself. R3 required reminders to use her call light for assistance with walking, and staff were to anticipate R3's needs. On 8/5/21, at 10:01 a.m. a progress note	21810		

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21810	Continued From page 11	21810		

indicated R3's safety was managed by placing R3 near the nurse's station.

On 10/26/21, at 9:50 a.m. R3 was observed lying in bed. R3's call light was hanging out of reach on the wall behind her bed. R3 began calling out, "I am going to die" and "Help me." At 9:53 a.m. nursing assistant (NA)-A entered R3's room and stated, "She's always like that," and took R3's meal tray. When asked where R3's call light was, NA-A stated, "Yeah, where is her call light?" NA-A verified R3's call light was hanging on the wall behind R3, and stated she was unsure why the call light was not within R3's reach. NA-A handed the call light to R3, who demonstrated the ability to use the call light.

On 10/27/21, at approximately 1:00 p.m. the director of nursing (DON) was interviewed. The DON stated call lights should be within reach for all residents. The DON stated she believed R3 was a fall risk, and could use the call light.

The facility policy Fall Assessment and Managing Fall Risk reviewed 11/14/19, directed standard fall reduction interventions for all residents included call lights placed in reach and accessible to resident when resident is
in their room.

SUGGESTED METHODS OF CORRECTION:
The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all residents have their call lights within reach. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21810	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		