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	03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redeemer Residence Inc	625 West 31st Street Minneapolis, MN 55408

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48037 Based on observation, interview and document review, the facility failed to ensure comprehensive trauma assessments were completed to ensure appropriate treatment and services for 6 of 6 residents (R1, R2, R3, R4, R5 and R6) who had a history of traumatic events. Findings include: Facility matrix for providers identified one resident triggered for post traumatic stress disorder (PTSD)/Trauma in the facility. R1's face sheet identified R1 had diagnoses that included cerebral palsy, mood disorder due to known physiological condition and anxiety. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 was cognitive and did not display behaviors. R1's abuse assessment observation dated 4/26/23, identified R1 had a history of being abused by others. Stepfather was an alcoholic and he was in the service so he would hurt her because she was from Yugoslavia. Although R1's record identified R1 had a history of past abuse a comprehensive trauma assessment that would identify potential triggers and interventions in order to attain or maintain the highest practicable mental and psychosocial well-being R1's care plan dated 9/27/23, identified R1 was at risk for abuse, had a history of abuse or neglect, and reported history of physical abuse from her father. R1 was alert and oriented and would be able to report abuse/neglect. R1's care plan did not address trauma related goals and interventions. Facility reported incident (FRI) dated 2/10/24, identified R1 reported yesterday a staff member asked R1 if he could touch her private part. R1 said no and he left the room. The staff member returned and asked R1 if she would touch his private part. R1 told him no and left the room. There was no physical sexual contact in the genital or breast area. There are no physical injuries at this time. A staff member was currently with R1 to get a full picture of emotional well-being. (continued on next page)

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

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Progress note dated 2/11/24, identified R1 refused to be changed in the overnight shift in the presence of the writer and nursing assistant that shift. Progress note dated 2/14/24, indicated social worker met with resident on 2/12/24 to review incident (from 2/11/24) and check on psychosocial well-being. Resident reviewed with social worker the above incident. Social worker asked resident if she feel safe and she responded yes. Resident was not in any distress and was ready to eat her lunch. R1's record did not identify completion of a PHQ-9 (mood) assessment and/or a trauma assessment following the allegation. During interview on 3/6/24 at 9:12 a.m., R1 reported an allegation of unwanted touching and sexual requests which made R1 uncomfortable. During interview R1 mentioned a history of sexual abuse by father which led to R1 having ongoing fears regarding males throughout R1's life. During interview on 3/8/24 at 8:47 a.m., family member (FM)-A stated R1 was mentally and physically handicap and very vulnerable. FM-A reported R1 had made multiple allegations about male staff touching her and responding inappropriately. FM-A was unsure if these allegations were due to a new experience, or the allegations were a result of R1's past history with her father because there was strong suspicion R1 had been raped by him. Since FM-A was not sure if R1's allegations were a result of past trauma or if allegations of sexually inappropriate behaviors by staff were true, FM-A immediately reported to facility staff for further investigation. During interview on 3/6/24 at 12:24 p.m., director of nursing (DON) reported R1's abuse allegation ultimately ended up being unsubstantiated by the facility, and it was identified the allegation may be due to R1's past history of trauma. R1 declined ACP (associated clinic-psychology) services and on call provider was notified. R2's face sheet identified R2 had a diagnosis which included traumatic hemorrhage of cerebrum (bleeding in the brain), with loss of consciousness of unspecified duration. Diffuse traumatic brain injury with loss of consciousness of unspecified duration. R2 had aphasia following cerebral infarction. R2's entry tracking Minimum Data Set (MDS) dated [DATE], did not identify a brief interview for mental status was conducted (BIMS). R2 required substantial/maximal assistance for toilet hygiene, partial to moderate assistance for lower body dressing and supervision or touching assistance for personal hygiene. During interview on 3/6/24 at 10:16 a.m., R2 had difficulty with speaking related to medical diagnosis. R2 reported being inappropriately touched by a male staff member. R2 felt uncomfortable and scared. R2 indicated she did not want men in her room. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2's care plan dated 8/28/23, identified R2 was admitted for rehabilitation and skilled care due to traumatic subdural hemorrhage with loss of consciousness of unspecified duration. Interdisciplinary team was to assist resident with discharge planning. R2 was at risk for mood disturbance related to diagnosis of depression. Potential alteration in mood exhibited by flat affect. Staff will work with resident and family to identify causes of mood problems an identify effective interventions and coping strategies. R2's communication had improved some and can get general message and feelings out verbally. R2 does understand. Staff are to report any changes in ability to communicate and understand others. R2's abuse assessment observation dated 8/30/23, identified R2 had a history of being abused by others and R1 had physical and cognitive disabilities which made R2 susceptible to abuse. R2 did not have any behaviors which made R2 susceptible to abuse. R1 had communication limitations which increased R2's susceptibility to abuse including wearing glasses and R2's hearing was fair. R2's PHQ-9 (mood interview) score dated 12/29/23, with a score of 5 indicating major depressive syndrome. In review of R2's record it was not evident a comprehensive trauma assessment had been completed. R2's progress note dated 2/28/24, identified staff member found urine on the floor in R2's room. Reminded resident to ask for assistance for any needs. R2's progress note dated 3/4/24, identified R2 had been refusing cares while laying down in bed. Resident refused pad changing, blood sugar, g-tube flushing, dressing and lunch. Risk and benefit explained, redirected, and encouragement done but with no affect. Monitoring continues. During interview on 3/7/24 at 12:54 p.m., R2's power of attorney (POA) indicated they were responsible for R2's health care decisions. POA reported R2 did not like men in her room nor like men around her. POA explained R2's fear of men started in July of 2023 when R2 was attacked at a party and was raped, causing her to need admission into the nursing facility. POA stated R2 started pointing at male care givers in the past two weeks. One time when POA was present in R2's room with a male staff, R2 pointed at the staff and said things like, I don't want this!, Leave!, Not you! POA remembered another instance when R2 said sex me and pointed at her vagina. POA reported R2 had only been pointing and refusing care from male staff. POA felt this may be due to R2's experience of being raped. FM-B reported never being asked by facility staff about R2's trauma or what events led to R2's admission to the facility. FM-B did not feel the facility staff had awareness of R2's recent history of rape and maybe why R2 had been refusing personal cases, such as using the restroom, from men. R3's face sheet identified R3 had neurocognitive disorder with lewy bodies and dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. R3's significant change Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment. R3 was dependent for toilet hygiene, required substantial/maximal assistance to shower and bathe self as well as upper body and lower body dressing. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's abuse/psychosocial well-being care plan dated 11/29/21, indicated was at risk for abuse or neglect due to vulnerable status living in skilled nursing facility. R3 had occasional periods of confusion and delusional thoughts. R3 had a history of abuse or neglect from childhood and spousal abuse. R3 had periods of night [NAME]. The care plan intervention directed staff to complete abuse prevention observation per protocol. R3's abuse assessment dated [DATE], identified R3 had history of self-abuse and refusing care. R3 had a history of being abused by others [childhood and spouse]. R3 did have physical limitations, cognitive deficits, and communication limitations. Although R3's abuse assessment and care plan identified R3 had a history of abuse, there was no indication a comprehensive trauma assessment had been completed. During interview on 3/6/24 at 1:12 p.m., R3 reported she did not want male staff members to touch her for any reason. R3 reported uncomfortable and unwanted touch by a male staff member and facility staff have not asked her about her concerns with male caregivers. R4's face sheet identified R4 to have dementia, borderline personality disorder, bipolar disorder and anxiety disorder. R4's quarterly MDS dated [DATE], did not identify R4's cognitive level and R4 did not have behaviors. R4 was dependent on toilet hygiene, upper body and lower body dressing and personal hygiene. R4's psychosocial care plan dated 11/21/19, identified R4 had a history of trauma; physical abuse as a child. Corresponding interventions directed staff to assist R4 to talk with daughters to provide comfort. The care plan indicated R4 had difficulty identifying triggers and preferred to keep things to herself. R4 declined assistance from mental health professionals. R4's behavior care plan dated 3/24/23, identified R4 had behaviors of refusing hygiene cares. R4 had aggressive behaviors of yelling. This was due to borderline personality disorder. Staff are to work with resident/family to identify situations which trigger behavioral expression and to identify coping skills which have worked in the past. Staff to assist resident using these coping skills. Although R4's care plan identified R4 had a history of trauma, in review of R4's record it was not evident a comprehensive trauma assessments were completed to assist R4 in the determination of triggers and appropriate interventions identified to attain or maintain the highest practicable mental and psychosocial well-being. During interview on 3/7/24 at 10:56 a.m., family member FM-(C) indicated R4 had a past history of trauma including being molested as a child. During interview on 3/6/24 at 10:34 a.m., nursing assistant NA-(A) reported R4 was resistive with cares and refused personal cares. NA-A was not sure if there was a reason for R4's refusals. During interview 3/7/24 at 9:25 a.m., clinical manager (CM)-A reported R4 was very resistive with care including personal cares. CM-A was aware of some sexual and physical abuse reported to her by FM-C, however, could not recall the specifics and was not aware of any specific interventions relating to the past abuse. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5's face sheet identified R5 had vascular dementia, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R5's quarterly MDS dated [DATE], identified R5 was cognitively intact. R5 required substantial/maximal assistance for toilet hygiene and bathing. R5 required substantial/maximal assistance for lower body dressing. R5's Abuse Observation dated 6/19/23, identified R5 had a history of being abused by others, Resident explained she had been abused by previous partners. R5's Social History and Psycho-Social Assessment Observation dated 6/19/23 identified R5 did not have a history of trauma or significant life event. R5's psychosocial care plan dated 6/9/23, was inconsistent with Abuse Observation dated 6/19/23; R5's care plan identified R5 had no known history of abuse or neglect. The care plan identified R5 was at risk for abuse/neglect due to vulnerable status living in a skilled nursing facility. Although R5's Abuse Observation dated 6/19/23, identified R5 had a history of being abused, in review of R5's record, it was evident a comprehensive trauma assessment had been completed. During interview on 3/7/24 at 2:20 p.m., R5 reported she did not feel comfortable with male care providers and did not want them assisting with personal cares because it made her feel uncomfortable. R5 explained if a male staff attempted to provide cares or take her to the bathroom she would tell them she did not want them in her room. R6's face sheet identified R6 had major depressive disorder moderate. R6's quarterly MDS dated [DATE], identified R6 to have moderate cognitive impairment. R6 was dependent for toilet hygiene, required substantial/maximal assistance to shower, and dependent for lower body dressing. R6's care plan dated 11/29/2021 identified R6 has no known history of abuse or neglect. Is at risk for abuse/neglect due to vulnerable status living in a skilled nursing facility, impaired mobility, weakness, require 24 hour care. Is able to identify unsafe situations. Is alert and oriented and would be able to report abuse/neglect. Resident has a history of self-abuse with refusal of cases. R6 Abuse Observation dated 10/13/22, identified R6 did not have a history of abuse. R6's chart lacked trauma assessments. During interview on 3/7/24 at 11:45 a.m., R6 reported a past history of sexual trauma specifically with men. R6 stated she had multiple experiences with this type of trauma with a person she had trusted and had a lot of respect for. R6 explained due to her experiences she has lost all respect for any man. R6 explained she felt comfortable with only one of the male staff members providing her personal cares because she had developed reporrt with him. R6 stated the facility has not offered help to deal with her past trauma. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 3/7/24 at 10:00 a.m., nursing assistant NA-(B) reported there were several women residents in the facility who did not like help or assistants from male staff. NA-B specifically named R1, R5, and R6. NA-B was aware R6 was okay with one male staff, but preferred females for personal cares. NA-B explained was aware of this information because she talked with residents who shared their past experiences. NA-B was unsure on how to provide trauma related care to residents who had a history of traumatic experiences and reported direct care staff did not receive that kind of information nor was it identified in resident care plans. During interview on 3/7/24 at 1:22 p.m., clinical manager CM-(B) was unaware of any residents who did not want male care givers. CM-B stated an awareness R2 had been assaulted; CM-B stated R2 did not address R2's history of trauma however CM-B was aware R2's history of sexual assault. CM-B reported R2 should have a trauma informed care plan given the details of R2's attack. CM-B stated if the facility were not aware of pas history of trauma, and the care plan was incorrect, they could unintentionally trigger a flashback. If a resident had a history of assault or abuse, the trauma should be identified on the care plan with appropriate interventions in order to mitigate the risks of retraumatization and/or coping with the trauma. During interview on 3/8/24 at 12:03 p.m., social worker SW-(A) reported R1's abuse observation identified past history of abuse and information was not passed on by the temporary social worker at the time. Floor staff would not know about this history as it was not care planned. Without having the past history of sexual abuse, R1 could be uncomfortable with male workers. Additionally, it could lead to allegations of abuse if the care provided unintentionally triggered a memory from R1's past. SW-A reviewed R2's, R3's, R4's, R5's, and R6's records and indicated there were unclear details about the abuse and the ongoing potential for trauma was not identified as a factor. SW-A explained without having appropriate interventions in place, residents could be retraumatized and it was best to know so individualized care and mental health services could be provided. During interview on 3/8/24 at 12:50 p.m. director of nursing (DON) explained there was a difference between between trauma care plans and vulnerability care plans. Trauma care plans specifically identified the trauma, addressed what the resident had been through, triggers, and how facility staff were to provide cares without causing stress to the resident. A vulnerability care plan identified the resident's vulnerability due to living in a nursing home and disabilities which may make them susceptible. It was important the facility identified the appropriate care plan and be more specific about the individualized needs. Staff needed to be aware of how to approach someone appropriately. Facility policy dated 10/14/22 titled Trauma Informed Care 1. Cassia facilities support a culture of emotional well-being and physical safety for staff, residents and visitors. 2. Trauma-informed care is culturally sensitive and person-centered. 3. Caregivers are taught strategies to help eliminate, mitigate or sensitively address a resident's triggers. 4. Trauma informed care is included in our QAPI program so that needs and (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Problem areas are identified and addressed. 5. The facility assessment will include a review of Trauma Informed care practices. 6. Each facility works with community support organizations and appropriate referral Agencies for services, referrals and education as indicated. 7. As a part of the admission comprehensive assessment the facility will identify history of trauma or interpersonal violence when possible using the Social history and psycho-social observation tool. 8. If a resident shares a history of trauma, a trauma informed care plan will be Developed with appropriate information to help guide staff in an effort to avoid Re-traumatization. 9. It is Cassia's expectation that our staff interact with all residents and visitors in a manner that is welcoming and kind without being intrusive.