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	06/05/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure resident and resident guardian's participation in the development of interventions for 1 of 1 resident (R44) reviewed for participation in care planning. Findings include: According to the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated October 2023, the RAI is used to, assist staff with evaluating goal achievement and revising care plans accordingly by enabling the nurse home to track changes in the resident's status. The RAI, establishes a course of action with input from the resident (resident's family and/or guardian or other legally authorized representative(, resident's physician and interdisciplinary team that moves a resident toward resident-specific goals utilizing individual resident strengths and interdisciplinary expertise. The Assessment Reference Date (ARD) refers to the specific endpoint for the observation period in the MDS assessment process and is federally mandated to be completed on admission, quarterly (every 92 days), annually, with a significant change in status (SCSA), and on discharge. R44's quarterly Minimum Data Set (MDS) dated [DATE], identified R44 with severely impaired cognition, was dependent on staff for toileting, lower body dressing, personal hygiene and needed supervision with showering. In addition, R44's diagnoses included traumatic brain injury, diabetes, aphasia (communication disorder affecting ability to express and understand language), dementia, seizures, depression, bipolar disorder (extreme mood swings) and psychotic disorder (abnormal thinking and perception). R44's face sheet identified family member (FM)-A as emergency contact, guardian, and primary financial contact. Review of R44's MDS assessments were documented for the quarterly on 3/18/25, and 12/31/24 for annual. Review of R44's electronic medical record (EMR) in the Observation tab, identified one care conference was completed and documented in 2025. The date of last care conference was 1/29/25. Phone calls to FM-A were attempted with no response. (continued on next page)

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with director of nursing (DON) on 6/4/25 at 12:19 p.m., DON stated care conferences should be completed with MDS assessments. DON reviewed R44's EMR and stated the March 2025 care conference was not done. DON stated expectation of all care conference summaries to be documented and located in the Observation tab of EMR. DON stated the facility's social worker (SS) was responsible for scheduling and documenting the care conference note and downloading it into the EMR. DON stated he did not know why the March 2025 care conference was not done. During interview with SS on 6/4/25 at 1:28 p.m., SS stated the social services department was responsible for scheduling the care conferences with residents, their family, and all primary departments such as nursing, therapy, dietary, and social services to review any changes or updates on resident progress and goals of care. SS stated the care conferences were to be scheduled during the same time as the MDS assessments including admission, quarterly, significant change in status, and discharge. SS reviewed R44's EMR and stated March 2025 care conference was not done and should have been, stating, my best guess is that we attempted to call [FM-A] but did not follow up. Facility policy titled Care Conferences and documentation of risk areas reviewed 4/11/2025 identified expectation of care conferences to be held quarterly and with significant change in status thereafter for long term care residents. In addition, the responsibility of coordinating and scheduling care conferences was the social services department.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the physician was notified of a change in condition for 1 of 1 resident (R32) reviewed for a change of condition. Findings include: R32's admission Minimum Data Set (MDS) dated [DATE], indicated R32 had intact cognition. R32's provider note dated 4/18/25, indicated R32 had a history of a deep vein thrombosis (blood clot, DVT) and a pulmonary embolism (blood clot in the lungs, PE) and remained on Apixaban (blood thinner) twice daily. R32 also had a history of a stroke requiring hospitalization from 12/26/24 to 1/2/25, diabetes, schizoaffective disorder, and cancer. R32's progress note dated 5/29/25 at 7:12 p.m., indicated R32 had an unresponsive episode where the nursing assistant (NA) observed R32 leaning to his left side so licensed practical nurse (LPN)-B was notified. The progress note indicated that LPN-B completed an assessment of R32. The note indicated R32's eyes remained open during the period, and a few seconds into the assessment, R32 was able to answer questions, follow LPN-B's fingertip with eyes, pupils were equal and reactive, hand grasp was strong and reactive, and R32 denied having a headache. R32's medical record was reviewed and did not indicate the provider had been notified of R32's unresponsive episode. R32's care plan dated 4/29/25 was reviewed and did not include a history of unresponsive episodes. During an interview on 6/4/25 at 10:37 a.m., registered nurse (RN)-C confirmed he was the nurse in charge of R32's care for the shift. RN-C stated he had been aware of R32 having previous episodes of hypoglycemia, but after reviewing R32's progress note referenced above, stated he hadn't heard of [R32 having] anything like this [unresponsive episode] before. RN-C stated he would have expected the nurse to contact the provider if R32 had an unresponsive episode and would expect this to be documented in the progress notes as this was the facility procedure. RN-C confirmed he had reviewed R32's medical record and did not see that the provider had been notified. RN-C stated he would contact the provider as he felt the issue was urgent and concerning. During an interview on 6/4/25 at 10:55 a.m., nurse practitioner (NP)-A stated she was not notified of R32's unresponsive episode. NP-A stated she expected the nursing staff to be her eyes and ears and would have expected the nursing staff to notify her of R32's unresponsive episode. NP-A stated she would have ordered additional monitoring of R32 and diagnostic testing to determine the cause of the incident. A call was made to LPN-B on 6/4/25 at 11:13 a.m., with a message left, and no return call was received. During an interview on 6/5/25 at 8:14 a.m., the unit nurse manager, RN-D, stated although she appreciated the assessment LPN-B had completed regarding R32's unresponsive episode, she would have expected LPN-B to contact the provider in case further recommendations were needed. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Notification of Physician and Resident Representative dated 3/10/25, indicated the facility expected the primary provider to be updated when the resident had a change of condition as soon as possible and this should be documented in the progress notes. The policy indicated the facility would expect the staff member to contact the provider if a significant change occurred in the resident's physical, mental, or psychosocial status, if there was a need to alter treatment significantly, or if the resident needed to begin a new form of treatment.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded with received medications to promote continuity of care and ensure accurate care planning for 2 of 2 residents (R122 and R311) reviewed for MDS accuracy. Findings include: R122 admission MDS, dated [DATE], indicated R122 was admitted to the care facility on 5/1/25. Section N of the MDS, used to indicated what, if any, high risk medications a resident received in the past seven days, indicated R122 has received insulin injections one time in the past seven days. R122's Physician Order Report, dated 5/1/25 - 6/4/25, lacked evidence R122 was on an insulin injection. The report did indicate R122 received an Ozempic injection once a week on Sundays for a diagnosis of Diabetes Mellitus Type II. However, according to the Resident Assessment Instrument (RAI) Manual for Long-Term Care, Ozempic should not be classified as an insulin injection or a high-risk hypoglycemic medication. Ozempic's classification aligns with its pharmacological profile as a GLP-1 receptor agonist with a lower risk of hypoglycemia. During an interview on 6/3/25 at 1:20 p.m., MDS coordinator-A stated the staff who coded R122's MDS no longer worked at the facility, and she would be unsure how to code Ozempic. MDS Coordinator-A stated she would have to refer to the RAI Manual or reach out for support from corporate. MDS Coordinator-A confirmed R122 was not receiving an insulin injection. R311's admission MDS, dated [DATE], indicated R311 was admitted to the care facility on 4/9/25. Section N of the MDS indicated R311 had received an antiplatelet and an anticoagulant medication in the past seven days. R311's Physician Order Report, dated 4/1/25 - 6/4/25, lacked evidence R311 was on an anticoagulant medication. The report did indicate R311 was on aspirin 325mg daily. However, according to the RAI Manual, aspirin should be coded as an antiplatelet medication, not an anticoagulant. During an interview on 6/3/25 at 1:28 p.m., MDS Coordinator-B confirmed R311 was not on an anticoagulant medication. MDS Coordinator-B stated Aspirin should be coded as an antiplatelet, not an anticoagulant, stating I think it is an error. During an interview on 6/4/25 at 10:38 a.m., the director of nursing (DON) agreed section N of R122's and R311's MDS were coded inaccurately. A facility policy on MDS was requested and not received.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a Level I Pre-admission Screening (PAS) and, if needed, a Level II Pre-admission Screening and Resident Review (PASARR) was completed to screen for mental health needs for 2 of 3 residents (R6, R32) reviewed for PAS. Findings include: R6's admission Minimum Data Set (MDS) dated [DATE], indicated R6 had intact cognition. R6's medical diagnoses list dated 5/20/25, indicated R6 was diagnosed with schizoaffective disorder with auditory hallucinations. R6's PAS notice dated 5/19/25, indicated a copy of the PAS was included with this notice but the PAS was not final until the lead agency sent a final determination to the nursing home. R6's entire medical record was reviewed and lacked evidence a final determination had been received. R32's admission MDS dated [DATE], indicated R32 had intact cognition. R32's medical diagnoses list dated 4/25/25, indicated R32 was diagnosed with schizoaffective disorder with an acute exacerbation. R32's PAS notice dated 5/7/25, indicated a copy of the PAS was included with this notice but the PAS was not final until the lead agency sent a final determination to the nursing home. R32's entire medical record was reviewed and lacked evidence a final determination had been received. During an interview on 6/4/25 at 2:21 p.m., the director of nursing (DON) confirmed he had reviewed R6's and R32's medical records and could not find the final PASARR determination for either resident. The DON stated they used to get the final PASARR faxed to them but recently the process changed and they were supposed to request the copies electronically from the lead agency and that had not been happening. The DON stated they will now work to change the process to ensure the final determination was received for each resident. The facility's Pre-admission Screening and Resident Review Policy dated 4/11/25, indicated copies of the PASARR approval would be uploaded in each resident's medical record.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure routine oral hygiene was completed to reduce the risk of complication for 1 of 4 residents (R39) reviewed for activities of daily living (ADLs) who were dependent on staff for their care. Findings include: R39's quarterly Minimum Data Set (MDS) dated [DATE], indicated R39 had moderately impaired cognition and did not have rejection of care behaviors during the look-back period (LBP). The MDS indicated that R39 required substantial assistance to complete oral hygiene. R39's care plan dated 5/19/25, indicated R39 had full upper dentures, natural teeth on the bottom, with the front teeth missing. The care plan indicated staff were to provide extensive assistance with oral care. R39's Point of Care History dated 5/3/25 to 6/2/25 was reviewed and did not include documentation of oral care. During an interview on 6/2/25 at 3:12 p.m., R39 stated staff were supposed to help her brush her teeth twice a day but had not been doing so. R39 stated they used to set a basin with a toothbrush on her bedside table and then leave but she was unable to complete the task by herself so now staff did not even do that much. During an interview on 6/4/25 at 11:46 a.m., nursing assistant (NA)-C confirmed she was R39's aide for the shift. NA-C stated that R39 had dentures and no real teeth. NA-C stated she had assisted R39 with putting her dentures in this morning but as R39 had no real teeth, had not brushed any. During an observation on 6/4/25 at 11:51 a.m., R39 was observed lying in bed. R39 was observed to have no upper teeth, with the front couple of bottom teeth missing with teeth remaining on both the bottom left and right side of the mouth. R39's teeth were observed yellowed with a white/yellow matter observed around the bottom edges of teeth. During an interview on 6/5/25 at 8:33 a.m., registered nurse (RN)-B, the unit nurse manager stated oral hygiene was the standard of care and staff needed to assist residents with completing this preferably twice a day. RN-B stated assisting the resident with oral care was important, so oral bacteria does not spread and to prevent things like gingivitis. RN-B stated, the only place he could think of that staff may document that oral care was completed was on the POC (point of care) charting. A policy regarding oral care was requested and not received.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a developed skin condition was appropriately and consistently treated to promote healing for 1 of 2 residents (R49) reviewed who had developed dry skin. Findings include: R49's annual Minimum Data Set (MDS), dated [DATE], identified R49 had intact cognition and demonstrated no delusional thinking. Further, the MDS recorded R49 received dialysis and had no current ulcers, wounds or other skin problems (i.e., burns, lesions). R49's care plan, revised 5/19/25, identified R49 required assistance with activities of daily living (ADLs) due to multiple medical conditions including hemiparesis. The care plan outlined R49 was at risk of altered skin integrity due to heart failure and R49 had a history of pressure ulcers. The care plan listed multiple interventions to help R49's skin remain intact including, Moisturize dry skin. On 6/2/25 at 7:09 p.m., R49 was observed lying in bed while in his room. R49 was interviewed and expressed he had dry, itchy skin on his arms and legs which he didn't feel was being treated. R49 stated staff were supposed to be applying a lotion or oil to it a few times each day; however, it wasn't being consistently done. R39 showed his arms which were visibly dry with areas of white-colored skin (i.e., flaky) present. R49's Progress Note, dated 3/20/25 and completed by the medical provider, identified R49 was seen following a hospitalization. The note included text which read, . on exam[,] patient skin is very dry and scaley. this [sic] is chronic almost. will [sic] benefit from a lotion for dry skin. The note listed a section labeled, Plan, which directed, Orders: Start cerave cream apply to skin twice a day. A corresponding View Prescription Order, printed 6/4/25, was authored by another medical provider and listed a received date, 03/20/2025. The order named the CeraVe with directions, Apply CeraVe Cream BID [twice daily] topically head-toe for severe Dry Skin. (Okay for alternative topical cream). On 6/4/25 at 8:09 a.m., R49 was again observed in his room, now seated in a high-back Broda-style wheelchair. R49 continued to have visible dry skin with some areas of light white-colored scaling present on his arms and hands. R49 reiterated nobody was consistently applying lotion or cream to his dry skin adding aloud, Nope. R49 expressed, I think I need it. R49's Medication Administration Record (MAR), dated 5/2025, identified R49's order for CeraVe cream to be applied topically BID with a listed start date, 03/20/2025 - Open Ended. The MAR outlined an, AM, and, HS [bedtime], time for administration along with staff initials to record the administration or refusal. This treatment was recorded as being completed the entire month during the morning (i.e., AM) shift; however, had 12 recorded days on the evening (i.e., HS) time frame of being not administered with added text, Not Administered: Drug/Item Unavailable. R49's MAR, dated 6/2025, identified the same order for CeraVe and, again, spacing to record it's administration or refusal. This identified only three days (1/1 to 1/3) of history recorded; however, again, showed one of the six doses as not administered with added rationale, Drug/item Unavailable. The MAR lacked evidence of what, if any, alternative cream or lotion had been applied on days when the CeraVe was not available. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 6/4/25 at 9:04 a.m., nursing assistant (NA)-B verified they had worked with R49 prior and described him as needing total care from staff. NA-B stated they had noticed R49 to have dry skin and expressed aloud, He's always had very dry skin, always. NA-B stated they sometimes applied lotion to R49's skin but not consistently, and expressed they were unsure what, if any, treatments the nurses were doing for it. Further, NA-B stated R49's dry skin condition was the same over the past several weeks and reiterated, He's very dry. On 6/4/25 at 9:46 a.m., registered nurse (RN)-E was interviewed, and verified they routinely worked with R49. RN-E stated R49 was on dialysis and expressed they had noticed R49 to have had frequent dry skin. RN-E stated R49 had an order for fancy lotion [i.e., CeraVe] awhile prior but the insurance wouldn't cover it so, as a result, they (RN-E) had just been applying A&D ointment (a skin protectant ointment) to his skin. RN-E stated the nurse working should catch and resolve a discrepancy between the MAR and any applied topical medications or creams, and acknowledged R49's current order in the MAR still called for the CeraVe lotion to be applied. RN-E attributed the lack of clarification being obtained to, We've been using A&D and [we're] so busy you know, adding further, I haven't had a chance to update it [MAR]. RN-E stated they were unsure what cream or ointment the other nurses working with R49 were using and reiterated the use of A&D ointment was what I do. Further, RN-E verified there was no current supply of CeraVe in the medication cart, and stated they felt R49's developed dry skin was about the same over the past weeks. R49's medical record was reviewed and lacked evidence the progress note directing CeraVe and the physician order, completed by a different provider, were clarified to ensure the correct product was being applied; nor did the record have evidence of what, if any, attempts were made to obtain the CeraVe lotion despite apparent insurance refusal to cover it. The record lacked evidence what, if any, additional interventions had been considered or developed despite R49's skin condition remaining and not improving over several weeks as observed by the direct care staff; and further, the record lacked any recorded dictation or evidence of what, if any, cream or lotion staff had been applying to R49's skin when signing off on the MAR the treatment was done despite the CeraVe not physically being present in the care center per direct care staff. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/25 at 10:59 a.m., registered nurse manager (RN)-B was interviewed, and verified they had an opportunity to review the medical record. RN-B explained the CeraVe wasn't covered by R49's insurance and expressed what typically happens in such a case would be the care center considering to cover the cost of it instead. RN-B stated they had just called the pharmacy and the medication (CeraVe) would be sent over that day. RN-B stated they followed-up with RN-E who confirmed they had been applying A&D ointment instead, and RN-B directed RN-E the provider should be updated and order changed. RN-B verified the ordered CeraVe was not physically present on-campus and expressed none of the nurses had updated them on it not being filled or available. RN-B stated they recalled seeing a communication from pharmacy about it not being covered but it had just been overlooked since then. RN-B stated it was important to ensure ordered treatments are done as they were ordered for a reason adding aloud, We should follow the order. RN-B verified if a medication was not available, then the provider should be updated and order clarified or obtained adding, You want to follow the doctor's order. RN-B stated not clarifying an order or updating the provider could be a bigger problem if it involved more than lotion. Later on 6/4/25 at 12:04 p.m., RN-B was interviewed and provided the physician's order which outlined use of an alternative lotion and/or cream was allowable. RN-B stated use of A&D ointment in place of CeraVe wouldn't be my first choice and acknowledged them to have different ingredients. RN-B reiterated nurses should be reporting creams and medications which weren't available adding, So I can check into it. RN-B verified the MAR lacked evidence of what, if any, cream or lotion had been applied to R49's skin despite the CeraVe not being available and, as a result, acknowledged there was no way to know what, if any, treatment the nurses were actually doing. RN-B stated it was important to ensure ongoing, consistent treatment for R49's dry skin was done as he was more prone to breakdown. On 6/5/25 at 10:37 a.m., the director of nursing (DON) was interviewed. DON verified R49 had the CeraVe delivered that morning and expressed staff should be using an alternate lotion on R49's skin like a Eucerin (lotion) which were available in the medication carts. DON stated the same treatment should be applied amongst all the nurses, and verified if a medication is repeatedly unavailable then staff should update the nursing leadership. DON stated using the same, ongoing treatment modality would help ensure better healing. A facility-provided Skin Integrity policy, dated 3/2025, identified a procedure which included the NA doing daily skin checks and updating the nurses with concerns. The policy continued, Nurse will implement appropriate treatment for new skin alterations using wound care protocol or base on Provider recommendations. The policy lacked specific information or directions on how to address a skin concern which was not a pressure ulcer or wound (i.e., dry skin).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to follow infection control standards of practice for cleaning of hard surfaces in the resident room for 1 of 1 residents. In addition, the facility failed to ensure personal laundry was transported and delivered in a manner that prevented risk of contamination for 1 of 3 hallways (3rd floor) observed for linen transportation. In addition, the facility had failed to ensure transmission-based precautions (TBP) were assessed for and implemented timely for 1 of 1 residents (R39) reviewed with symptoms of a possible gastrointestinal illness. Findings include: Wheelchair arm rests: According to the Centers for Disease Control (CDC) Guidelines for Environmental Infection Control in Health-Care Facilities (2003) the cleaning and disinfection of environmental surfaces is fundamental in reducing their potential contribution to the incidence of healthcare-associated infections. R44's quarterly Minimum Data Set (MDS) dated [DATE] identified R44 with severely impaired cognition, was dependent on staff for toileting, lower body dressing, personal hygiene and needed supervision with showering. In addition, R44 diagnoses include traumatic brain injury, diabetes, aphasia (communication disorder affecting ability to express and understand language), dementia, seizures, depression, bipolar disorder (extreme mood swings), and psychotic disorder (abnormal thinking and perception). During observation on 6/2/25 at 2:43 p.m., R44 was laying bed with clothes on. Their wheelchair was located near foot of bed and had visibly crackled vinyl armrests with foam padding noted under the material which was pulling away. During observation and interview with nursing assistant (NA)-A on 6/4/25 at 9:15 a.m., NA-A looked at R44's wheelchair arm rests and stated, Yes, that wheelchair is really shabby looking and broken up like cracked material. I can see the foam under the cracked material and even the metal portion of the arm rest. During observation and interview with trained medication aide (TMA)-A on 6/4/25 at 1:22 p.m., TMA-A looked at R44's wheelchair arm rests and stated, not a cleanable surface because it is worn out. During observation and interview with 3rd floor nurse manager (RN)-A on 6/4/25 at 1:25 p.m., RN-A looked at R44's wheelchair arm rests and stated, [they] need to be replaced because it is rough and [sic] the edges and could harbor infection. During observation and interview with DON on 6/4/25 at 1:37 p.m., DON looked at R44's wheelchair arm rests and stated, I agree that it is not smooth surface to clean and wipe down. Material is cracked and should be smooth and stated it was, a concern for infection control. During interview with facility's infection control preventionist (ICPC) on 6/4/25 at 1:55 p.m., ICPC looked at R44's wheelchair arm rests and stated, Yes that would not be a cleanable surface at this time. Armrests should be a smooth surface. I agree it is a concern for infection control. (continued on next page)

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	06/05/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview with housekeeper (HK)-B on 6/5/25 at 10:05 a.m., HK-B described expectation of housekeeping staff to wipe wheelchairs only if I see visible dirt. HK-B stated if material on arm rests were cracked and peeling then I would not be able to clean it correctly. [sic] could be a place for germs to grow. Linen cart: During observation on 6/4/25 at 9:10 a.m., laundry aide (LA)-A wheeled a laundry cart to 3rd floor hallway outside 3 [NAME] unit, obtained personal laundry from the cart and left the cart uncovered before walking away. Personal laundry was visible on the clothes hangers. At 9:11 a.m., LA-A returned to the uncovered laundry cart with empty clothes hangers in her hands and then wheeled the uncovered laundry cart past nursing station, dining room with three residents sitting in wheelchairs, and the main hallway past resident rooms. When she approached main elevators LA-A pulled the folded-up linen cover over the laundry. During interview with LA-A on 6/4/25 at 9:12 a.m., LA-A stated, I left the [laundry] cart here uncovered and walked away. It should be covered because of [risk of] contamination and some residents could access it [unattended]. Facility policy titled Standard precaution reviewed 7/3/24, state, Standard Precautions apply to all patients and in all situations, regardless of diagnosis or presumed infection status. Because all residents can serve as reservoirs for infectious agents, adherence to Standard Precautions during the care of ALL residents is essential to interrupting the transmission of microorganisms. Standard precautions also intend to protect residents by ensuring that healthcare personnel do not carry infectious agents to residents on their hands or via equipment used during resident care. In addition, the policy identified procedure for, Handling and transporting of linen in a manner that avoids skin and mucous membrane exposure and avoids contamination of clothing. TBP The CDC guideline titled Summary of Recommendations, Guidelines for Isolation Precautions: Preventing transmission of Infectious Agents in Healthcare Settings dated 11/27/23, indicated in addition to standard precautions, TBP should be used with residents with known or suspected infection where additional precautions are needed to prevent transmission. R39's quarterly MDS dated [DATE], indicated R39 had moderately impaired cognition and was diagnosed with heart failure, kidney disease, and diabetes. R39's care plan dated 5/19/25, was reviewed and did not include a history of nausea and vomiting. R39's progress note dated 6/3/25 at 3:10 p.m., indicated R39 had complained of nausea and vomiting after both breakfast and lunch. The progress note indicated R39 had three episodes of vomiting during shift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on 6/4/25 at 8:10 a.m., NA-C was observed to enter R39's room, complete hand hygiene, and apply gloves. R39 stated she felt really nauseous today and her stomach was and explains using hand waving in a circular motion. R39 then asked NA-C for her throw-up container. NA-C was observed to hand R39 an empty water jug. NA-C was observed to assist R39 with personal hygiene tasks such as perineal care, washing under skin clean-folds, and washing face while R39 held empty water jug close to her mouth. R39 stated she had been feeling nausea since, not last the night of 6/2/25 and was vomiting yesterday and this was abnormal for her. NA-C was observed to remove gloves when cares were completed and complete hand hygiene. No further personal protective equipment (PPE) such as a gown or mask observed to be used. During an interview on 6/4/25 at 8:35 p.m., the ICPC, a registered nurse, stated they were now going to start utilizing droplet precautions when caring for R39. The ICPC stated she had reviewed R39's progress notes this morning and noticed that R39 had nausea and vomiting the previous day, so she was going to implement the precautions as this could be a symptom of an infectious disease. The ICPC stated she would have expected the nurse who was care for R39 at the time the symptoms had started to implement the precautions yesterday but that had not occurred. RN-E stated she had notified the provider yesterday of R39's nausea and vomiting and the provider had ordered a clear liquid diet but had not mentioned the need for precautions, so she had not implemented any. The facility's Transmission-Based Precautions, Enhanced Barrier Precautions and Empiric Precautions policy dated 5/13/25, indicated residents with a suspected or confirmed case of a communicable disease that was spread by droplet or contact with an infection environment should be placed on TBP until the condition has been ruled out or the criteria for removal from isolation had been met.