STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245520	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to report an allegation of neglect to the administrator and State agency (SA) for 1 of 5 residents (R21) reviewed for allegations or abuse and/or neglect. Findings include: R21 was interviewed on 3/02/20, at 2:39 p.m. and said on 1/19/20, he was out of the faciltiy and came back around 8:35 p.m. R21 went to the side entrance door and rang the buzzer to be let in, but no one responded to the buzzer. R21 said the temperature outside at that time was approximately 9 degrees Fahrenheit. R21 then called the facility number which went straight to voicemail, R21 continued to call with no answer and pounded on the door. R21 knew there was a camera at the door and the monitor was located on 3rd floor for staff to view who rang the buzzer. R21 stated he was cold but there was no place to go for shelter because he used a cane and felt he did not have the strength to walk far and there was ice on the sidewalls. R21 continued to pound on the door and rang the buzzer. R21 then called 911 and the police arrived. Shortly after the police arrived, a staff person happened to leave the building and let R21 and the police into the building. R21 said he was outside for about 40 minutes. R21 said no one from the facility staff came the next day to apologize or talk to him. R21 said he reported the incident to staff and told them he felt it was negligent to not have a buzzer that worked. R21 said he requested to know from the administrator what was to be done about the door buzzer, but was not given any information. R21's medical record had one progress note in regards to the incident dated 1/19/20. The note indicated, Resident was out for shopping, came back around 2040 as he claims. Tried to call the phone at the door 5 X, but the phone call took him to the voicemail. The resident called 911, to help him get inside the building. One staff member was going outside and found the resident with the Policeman and opened the door for the resident. Assessment was done and VSS, updated on the Matrix. Neuro's are ok. Nursing would continue to monitor. The record lacked any documentation the incident had been reported to the administrator or others per policy. The director of nursing (DON) and administrator were interviewed on 3/04/20, 9:18 a.m. The DON stated she was aware the incident happened but was not sure if the buzzer worked or not at the time of the incident and also not sure if the phones worked properly. The DON verified the facility did not report the incident to the SA because R21 was safe and un injured. The DON was aware the police had been called and R21 did get in the building but was not sure of the details. The administrator was also not sure of details, but the incident was discussed in morning meeting and there was a sign on the door for a number to call because the buzzer did not work. The Administrator verified notes were not kept for the stand-up meetings and since the incident was not reported to the SA and no investigation on the incident had been conducted. The vulnerable adult policy, dated 10/31/19, indicated all residents have the right to be free from abuse, neglect, misappropriation of property, and exploitation. All staff must immediately report suspected, abuse, neglect, or mistreatment of [REDACTED]. The policy also indicated the administrator would be notified immediately and a report would be made to the state agency.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan which was reflective of the resident needs for 1 of 1 resident's (R38) reviewed for urinary catheter care. Findings include: R38's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R38 had moderate cognitive impairment, and required extensive assist with toileting, activities of daily living (ADL's), and surface to surface transfers. The MDS further indicated R38 had [DIAGNOSES REDACTED]. The MDS further indicated a nursing quarterly evaluation of bowel and bladder was performed and included the statement No changes to plan of care at this time. Resident is incontinent of bowel. Resident has suprapubic catheter. R38's Care Area Assessment (CAA) dated 7/17/19, indicated R38 had a suprapubic catheter and staff were to provide catheter cares per physician orders. R38's care plan with last revised date of 2/26/20, indicated R38 had an alteration in elimination of bowel and bladder related to impaired mobility, [MEDICAL CONDITION] bowel and bladder due to [DIAGNOSES REDACTED]. The care plan lacked direction to staff regarding the frequency of when the catheter should be changed. On 3/02/20, at 2:35 p.m., R38 was observed in his room and sat in a wheelchair. White debris and sediment were visible in the catheter tubing. On 3/03/20, at 1:24 p.m., R38 was observed in his room in his wheelchair. A large amount of white sediment and debris were visible in catheter tubing. On 3/04/20, at 7:29 a.m., R38 was observed in bed, covered with blanket up to his chest. Catheter tubing continued to have a large amount of white debris visible, and approximately 150 milliliters (ml) dark amber colored urine visible in catheter bag. On 3/4/20, at 11:01 a.m., R38 was observed in bed. R38 verbalized he ate breakfast, but did not feel well and wished to stay in bed. Approximately 150 ml dark amber colored urine was visible in the catheter bag. On 3/04/20, at 11:36 a.m., Registered Nurse (RN)-B stated he would change R38's suprapubic catheter dressing. When R38's brief was opened, a strong urine odor was noted. After the dressing was changed, RN-B verbalized R38 appeared to have low urine output, urine appeared dark and cloudy and RN-B would flush the catheter and have R38 drink more fluids. RN-B further stated the catheter was to be changed every 2 weeks or as needed (PRN). RN-B attempted to flush catheter tubing, but was not successful, and verbalized the catheter would need to be changed. On 3/04/20, at 2:53 p.m., R38 was observed in bed with his eyes closed. Catheter tubing appeared clean with approximately 200 ml straw yellow urine visible in catheter bag. On 3/05/20, at 9:52 a.m., nurse manager, RN-A was interviewed and verified R38's care plan stated to follow physican orders regarding how often to change catheter tubing, and no further direction on changing catheter tubing was present in the care plan. RN-A further verified no written orders were present in R38's medical record to indicate how often to change catheter tubing. RN-A stated the previous order to change catheter tubing was likely not re-entered after R38 returned from a hospitalization on [DATE]. The care plan was updated on 3/5/20, and directed staff to provide catheter cares per physician orders [REDACTED]. On 3/05/20, at 11:58, a.m. the Director of Nursing (DON) was interviewed and stated it would be her expectation that there would be an order in place to direct when urinary catheters should be changed/replaced. The facility policy titled Care plan and baseline care plan, last reviewed 1/3/20, was reviewed. The policy indicated the facility will develop and implement a baseline care plan for each resident that includes instructions needed to provide effective and person centered care for the resident that meets professional standards of quality of care. The policy further indicated the resident care plan is to be updated routinely in the electronic record to reflect the resident's current condition.
F 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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

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 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Based on interview and document review the facility failed to inform and update 2 of 2 residents (R12, R236) of their discharge planning process and status, and failed to follow-up with referral agencies to determine progress of discharge planning into the community. Findings Include: During interview on [DATE], at 1:28 p.m. R12 explained he wanted to move back to his own apartment and felt the facilty did not provide the assistance to discharge back to the community. R12 indicated the Director of Social Service (DSS) had not informed him of the discharge status and plans. He further explained he had asked the DSS about the status of discharge into the community numerous times but the DSS had not gotten back to him with an update. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], indicated R12 had moderate cognitive impairment, was independent with bed mobility, transfers, eating and locomotion on and off the unit. Required supervision with toileting, dressing and personal hygiene. During interview on [DATE], at 12:42 p.m. DSS indicated she had no documentation in the electronic record of communication with relocation worker or updates to the resident about the progress and status of discharge plans into the community. DSS further explained she had recommended assisted living placement for R12, and had had interactions with relocation worker and made attempts to contact them, but did not chart any details in R12's electronic records. Review of Social Service assessment dated [DATE], and [DATE], indicated R12 worked with the relocation worker. On [DATE], DSS indicated she had made referrals to Health and Human services for relocation services. Review of progress notes from [DATE], through [DATE], lacked documentation that follow-up was done with referral agencies or a relocation worker. There was no documentation in the progress notes that R12 was updated on the status and progress of discharge plans. R236 When interviewed on [DATE], at 3:10 p.m. R236 stated she was unaware of her discharge status and the Director of Social Service (DSS) had not provided any update in regards to the discharge into the community. R236 indicated she had inquired of DSS several times but was told by DSS, Will get back to you, however had not come back with information regarding discharge plans and status. Review of annual MDS dated [DATE], indicated R236 was cognitively intact with a discharge plan in place for return into the community. During interview on [DATE], at 12:18 p.m. DSS explained R236 was on a wait list to get public housing, however a 6 month time frame had expired and needed to reapply. DSS had not heard from the relocation worker, although she had communicated with the relocation worker in [DATE]. DSS also stated although she had gone and explained to R236 about the status of her discharge planning, no documention was charted in R236's records to indicate that an update on discharge process was completed with R236. DSS further explained it would typically be the process to document in the records any updates communicated with R236. Progress Notes Review: -[DATE], Social Service assessment was completed and indicated resident had a relocation worker at Redeemer Services, with recommendation that included discharge to assisted living or apartment with services. -[DATE], Social Service assessment completed that indicated R236 worked with a relocation worker. -[DATE], Social worker met with resident to issue a 7 day transfer. Review of progress notes from [DATE], through [DATE], lacked documentation that R236 was updated by DSS in regards to the discharge process and status. Review of facility's Discharge Planning and Ombudsman Notification Policy revised [DATE], indicated: The Resident and resident representative will be involved in the discharge planning process and will be informed of the final discharge plan. Documentation of the IDT (Interdisciplinary Team) discharge planning discussions, ongoing interventions and Resident/resident representative teaching will be recorded in the Electronic Health Record (EHR). The Social Services Department is responsible for coordination of the resident discharge planning and for the coordination services necessary to meet the resident's care needs at the time of discharge. Referrals to local contact agencies or other appropriate entities will be documented in the EHR. When a discharge to the community is not feasible, this determination will be documented in the EHR.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to adequately inspect the door security system to ensure residents were able to gain access to the building after 8:00 p.m. for 1 of 1 residents (R21) reviewed for accidents. The facility also failed to ensure a call light was within reach for 1 of 1 residents (R22) who was reviewed for falls, and the facility failed to implement fall interventions were in place for 1 of 1 residents (R34) reviewed for falls Findings include: R21 was interviewed on 3/02/20, at 2:39 p.m. and said on 1/19/20, he was out of the faciltiy and came back around 8:35 p.m. R21 went to the side entrance door and rang the buzzer to be let in, but no one responded to the buzzer. R21 said the temperature outside at that time was approximately 9 degrees Fahrenheit. R21 then called the facility number which went straight to voicemail, R21 continued to call with no answer and pounded on the door. R21 knew there was a camera at the door and the monitor was located on 3rd floor for staff to view who rang the buzzer. R21 stated he was cold but there was no place to go for shelter because he used a cane and felt he did not have the strength to walk far and there was ice on the sidewalls. R21 continued to pound on the door and rang the buzzer. R21 then called 911 and the police arrived. Shortly after the police arrived, a staff person happened to leave the building and let R21 and the police into the building. R21 said he was outside for about 40 minutes. R21 said no one from the facility staff came the next day to apologize or talk to him. R21 said he reported the incident to staff and told them he felt it was negligent to not have a buzzer that worked. R21 said he requested to know from the administrator what was to be done about the door buzzer, but was not given any information. R21's medical record had one progress note that was in regards to the incident dated 1/19/20. The note stated, Resident was out for shopping, came back around 2040 as he claims. Tried to call the phone at the door 5 X, but the phone call took him to the voicemail. The resident called 911, to help him get inside the building. One staff member was going outside and found the resident with the Policeman and opened the door for the resident. Assessment was done and VSS, updated on the Matrix. Neuros are ok. Nursing would continue to monitor. The director of nursing (DON) and administrator were interviewed on 3/04/20 9:18 a.m. The DON stated she was aware the incident happened but was not sure if the buzzer worked or not at the time of the incident and also was not sure if the phones worked properly that evening. The DON verified the facility did not report the incident because R21 was safe and un injured. The DON was aware the police had been called and R21 did get in the building but was not sure of the details. The DON explained, the phone will ring at all stations at same time and if no one answers the phone will go to voicemail. The DON added, 8:00 p.m. to 9:00 p.m. was a very busy time for staff. The administrator was also not aware of the details, but the incident was discussed in morning meeting and there was currently a sign on the door for a number to call because the buzzer did not work. The Administrator verified notes were not kept for the stand-up meetings and since the incident was not reported to the State Agency, no investigation on the incident had been conducted. The DON and corporate nurse consultant provided additional information about the incident. They said the resident had never been outside, but was in the interior walkway and got stuck at the second interior door. When asked how they came to that conclusion, they said if you push the buzzer it will let you into the walkway. Licensed practical nurse (LPN)-A was interviewed on 3/05/20, at 12:06 p.m. LPN-A explained when she left work the night of 1/19/20, she went to the back door and saw the police and did not see R21 immediately because he stood behind the police. LPN-A indicated they were all outside, not in the interior walkway. LPN-A opened the door to see what the issue was. R21 said he had been outside and couldn't get in. LPN-A let them in and tried to get some information from the police but they did not give her any information. LPN-A said she then called the facility supervisor to report the event. LPN-A was not sure how long R21 was outside. LPN-A explained the buzzer rings on the 3rd west (3W) unit and there was a TV monitor to see who rang the buzzer. LPN-A said she worked on the 3W unit at the time of the incident, but did not recall if she heard the buzzer ring. LPN-A said it was possible to hear the buzzer even if staff were at the end of the hallway. R21 was interviewed again on 3/05/20, at 12:21 p.m. R21 said he was outside, not in the interior walkway. R21 explained when the receptionist leaves at 8:00 p.m. they are supposed to push a button to transfer calls from the front desk to the units, and he believed that did not happen on the day of the incident. R21 said he had a conversation with the administrator to see what the plan was so it would not happen again and felt he did not get a satisfactory response. R21 wanted results of the investigation but was told it was internal. The administrator was asked on 3/05/20, at 12:30 p.m. what was done to investigate the problem about the buzzer. and the administrator could not recall what was done to check the system or what the current status of the buzzer was. He said internal information technology (IT) staff had worked on it and believed something had been done. The administrator said when the buzzer was pushed it will ring at the reception area and 3W. On 3W there is a button to push to buzz in and a video monitor to see who is at the door. The administrator said there is a button to push as the reception desk to talk to someone at the door and thought there was a similar system on 3W but was not sure. He explained after staff buzz someone in the first door, they are watched on the monitor and buzzed in the second

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) door. When asked about process for how calls get transferred after 8:00 p.m. the administrator was not sure. Receptionist-B was interviewed 03/05/20, at 1:30 p.m. She said there was a night button on the phone and demonstrated how it would turn to green light. When the night button was activated all calls will ring at reception desk and on 3W. If the button was not pushed, the calls would go to voicemail. She was not sure about the other units. She said the buzzer rings on the unit and at reception at all times. She verified when the buzzer is pushed the door remains locked until staff push a button to to unlock the door. The building security policy was requested but not provided. Resident #22 Review of significant change Minimum (MDS) data set [DATE], indicated R22 was cognitively intact, with [DIAGNOSES REDACTED]. Review of Care Area Assessment (CAA) dated 9/24/19, indicated R22 was at risk for falls related to instability with balance. Resident was always incontinent of bowel and bladder and required extensive assistance with toileting. Staff were to ensure call light and frequently used items were within easy reach. During observation on 3/03/20, at 9:04 a.m. R22 laid in bed with left arm in sling. Hands wrapped with bandage on top of cast from wrist area to upper arm. Call light observed tied on left bed rail with call light out of R22's reach and top portion of the call button noted under left arm in sling. On 3/04/20, at 2:01 p.m. R22 was observed in bed and awake. Call light was noted tied to left bed rail but out of reach. Bed control noted on right side and R22 held onto the control. During interview on 3/04/20, at 2:18 p.m. registered nurse (RN)-A explained that R22 had a fall on 3/1/20, and RN-A discussed post fall with R22 and some interventions that could prevent further falls, for example the use of gripper socks. RN-A stated it was the expectation the call light be within reach of all residents and further went along with surveyor into R22's room and verified the call light was out of reach on the left side and tied to left bed rail. RN-A then removed call light from the left bed rail and moved to the right bed rail and placed call button within reach of R22's right hand. Review of facility's Fall Assessment and Managing Fall Risk Policy updated 2/28/19, indicated interventions that included: call lights are placed in reach and accessible to resident when resident is in their room. Resident #34 R34's significant Change Minimum Data Set ((MDS) dated [DATE], indicated R34 had moderate cognitive impairment and [DIAGNOSES REDACTED]. The MDS further indicated R34 required extensive assist with transferring, bed mobility, toileting and ADL's and was not steady during transitions and not able to stabilize without physical assistance. Nursing progress notes indicated R34 had 10 documented falls from 10/1/19, through 3/4/19. A Fall Risk Assessment completed 12/31/19, indicated R34 was a high falls risk. R34's falls care plan revised 1/21/2020, indicated R34 was at risk for falls related to history of falls, weakness, cancer diagnosis, dementia, depression, anxiety, [MEDICAL CONDITION], hearing loss, incontinence, and use of antidepressant, antipsychotic and hypoglycemic (low blood sugar) medications. R34's care plan directed staff to assist resident to get up by 8:00 a.m., offer toileting assistance every 2 hours while awake, toilet at 2:30 p.m. daily, bed at height so feet are flat on floor, and to encourage resident to attend activities in the afternoon to avoid being alone in her room at that time. On 3/4/20, at 7:33 a.m. R34 was observed in bed in a darkened room, laying on her back with eyes closed, snoring softly. -at 8:08 a.m. R34 was observed in bed in the same position as stated previously. -at 9:36 a.m. R34 was observed in bed in the same position as stated previously. -at 10:03 a.m. R34 was observed in bed in the same position as stated previously. On 3/04/20, at 10:04 a.m., Nursing Assistant (NA)-A was interviewed and stated R34 doesn't eat breakfast, and prefers to sleep later. NA-A further stated R34 was a fall risk, and does attempt to self-transfer without assistance. On 3/04/20, at 2:55 p.m., R34 was observed in her room, and laid perpendicular across the foot of her bed on her back and her head hung slightly off one side of the bed and both feet on the floor on the other side on the bed. R34's wheelchair was approximately 6 feet away, against the wall, and the bed was in the low position. The surveyor entered the room and asked R34 to use the call light to request help. R34 was able to use call light. -at 2:59 p.m., NA-B responded and assisted R34 into her wheelchair. NA-B wheeled R34 toward bathroom. R34 stated she does not need to use the bathroom, NA-B then wheeled R34 toward dining area. On 3/05/20, at 8:58 a.m. R34 was observed in her room and laid on the bed on the right side, covers were place up to her neck, and her eyes open, bed in low position. -at 9:28 a.m., NA-A entered R34's room, changed R34's brief, performed perineal care, activities of daily living (ADL's) and dressed R34 for the day. When asked if this was the time R34 normally got up, NA stated R34 normally got up later than this time. NA-A further stated since R34 does not eat breakfast, she normally doesn't get up until around 11:00 a.m. NA-A verbalized she would brush R34's teeth and comb her hair when she got up, but was staying in bed at this time. When asked if R34 was toileted at any scheduled time, NA-A stated R34 was taken to the bathroom before lunch. On 3/05/20, at 10:03 a.m., registered Nurse (RN)-A was interviewed and stated R34 was a falls risk. RN-A verified R34's care plan and stated R34 was to be up by 8:00 a.m. The surveyor informed RN-A that R34 was in bed as they spoke. RN-A verbalized R34 should be up in her wheelchair according to the care plan. RN-A further stated it would be his expectation the NA's would follow R34's care plan. RN-A stated if R34 laid down after lunch, she should be checked regularly, and encouraged to get up, although R34 preferred to stay in bed. RN-A verified the current care plan indicated R34 was to be taken to use the bathroom at 2:30 p.m. On 3/05/20, at 12:01 p.m., the Director of Nursing (DON) was interviewed and stated R34 had a lot of falls and had many interventions in place. When asked about the care planned intervention that indicated R34 should be awoken and transferred to wheelchair at 8:00 a.m., DON stated R34 previously would attempt to self-transfer at that time. DON further stated it would be her expectation nursing staff would follow the care plan as written. The facility policy, Fall assessment and managing fall risk, last revised 11/14/19, indicated fall risk and appropriate interventions to minimize risk of falls and/or risk of injury from falls is included in the care plan. The facility policy, Care plan and baseline care plan, last reviewed 1/3/20, was reviewed. The policy indicated the facility will develop and implement a baseline care plan for each resident that includes instructions needed to provide effective and person centered care for the resident that meets professional standards of quality of care. The policy further indicated the resident care plan is to be updated routinely in the electronic record to reflect the resident's current condition.