DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 26, 2021

CMS Certification Number (CCN): 245348

Administrator
The Estates At Rush City Llc
650 Bremer Avenue South
Rush City, MN 55069

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective April 14, 2021 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 26, 2021

Administrator
The Estates At Rush City Llc
650 Bremer Avenue South
Rush City, MN 55069

RE: CCN: 245348
Cycle Start Date: April 1, 2021

Dear Administrator:

On April 26, 2021, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
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DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: IL4H

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00994

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245348**
2.STATE VENDOR OR MEDICAID NO.
(L2) **635842000**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE ESTATES AT RUSH CITY LLC**
(L4) **650 BREMER AVENUE SOUTH**
(L5) **RUSH CITY, MN** (L6) **55069**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **03/01/2017**

6. DATE OF SURVEY **04/01/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **45** (L18)
13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Colleen Johnson FNE - NE II 04/20/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 04/23/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
April 9, 2021

Administrator
The Estates At Rush City Llc
650 Bremer Avenue South
Rush City, MN 55069

RE: CCN: 245348
Cycle Start Date: April 1, 2021

Dear Administrator:

On April 1, 2021, a survey was completed at your facility by the Minnesota Departments 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.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Terri Ament, Unit Supervisor
Duluth District Office
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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by July 1, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 1, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / 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 electronic 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	C 04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT RUSH CITY LLC	**650 BREMER AVENUE SOUTH RUSH CITY, MN 55069**

(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
E 000	Initial Comments On 3/29/21, through 4/1/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/29/21, through 4/1/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. 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 UNSUBSTANTIATED: H5348034C (MN64646), H5348035C (MN63189), and H5348036C (MN53268). 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		04/16/2021

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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure abuse allegations were reported immediately to the State Agency (SA) for 2 of 5 residents (R4, R32) reviewed for abuse.	F 609	All residents have the potential to be affected by the facility failing to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment,	4/14/21

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 609	Continued From page 2 Findings include: R4's Admission Record printed 4/1/21, indicated R4's diagnoses included Alzheimer's disease and major depressive disorder. R4's quarterly Minimum Data Set (MDS) dated 1/6/21, indicated R4 understood others and was understood, had a moderate cognitive impairment, and displayed symptoms of delirium with disorganized thinking, though did not display symptoms of delusions or hallucinations during the assessment period. R4's MDS further indicated R4 had frequent pain that affected day-to-day activities, and received pain medication on a scheduled and as needed basis. R4's care plan initiated 7/7/20, indicated R4 was at risk for abuse and/or neglect, and was at risk for a decline in cognitive and physical abilities related to Alzheimer's disease. Interventions for R4 directed staff to be aware of statements or signs and symptoms of abuse, and to report to R4's physician, director of nursing (DON), and administrator immediately. In addition, R4's care plan directed staff to monitor for signs of emotional distress, mood and behavior changes, follow the facility vulnerable adult and abuse reporting policy, and notify the state agencies as needed. R4's care plan indicated R4 had an alteration in mood and behavior, with a history of verbal aggression, being accusatory of staff, paranoia and delusions. R4's care plan directed staff to approach R4 in a calm manner and provide her with choices as able, administer medications ass ordered, and provide emotional support.	F 609	including all injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Immediate corrective action: Administrator, Director of Nursing and Director of Social Services were re-educated on responding to allegations of abuse, neglect, exploitation, or mistreatment of residents within the facility. Date of Completion: 03/31/2021 Recurrence will be prevented by: Education was provided to 100% of staff on abuse reporting expectations and time constraints. All Estates at Rush City staff were	

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F 609	Continued From page 3 R4's progress notes dated 3/26/21, at 3:10 a.m. indicated R4 had a fall, and complained of a sore wrist, though had no visible signs of injury at that time. R4's progress notes dated 3/26/21, at 6:09 p.m. indicated R4 had an X-ray of her right arm, which was negative for fractures or deviations. R4 continued to complain of a sore wrist. R4's progress note dated 3/27/21, at 9:16 a.m. indicated R4's hand remained swollen with a dark discoloration, and R4 complained of pain if her hand was examined by touching. R4's progress note indicated ice, elevation, and acetaminophen were used as needed for comfort. R4's progress notes dated 3/29/21, at 5:45 a.m. indicated R4 was not sleeping well and was on the call light very frequently, making requests for things like candy and medicine. R4's progress note indicated R4 was confused and was upset with staff for not understanding her and with attempts to re-orient her. R4's progress note indicated staff provided interventions as R4 needed. On 3/29/21, at 3: 05 p.m. R4 was interviewed and stated she had reported she had gotten upset "the other night" when she had need assistance, she asked a nursing assistant (NA) for something, and the NA responded abruptly. R4 stated the NA told her that she had to stop asking for things, because she (the NA) had so many things to do. The NA left the room without taking care of R4's needs. R4 stated she had needed pain medication for her hand, so she put on her call light and the staff told her she just wants more things, and left the room. R4 stated she did	F 609	assigned the Abuse Prevention in Persons with Dementia, Abuse, Neglect, and Exploitation Prevention, and Elder Justice Act on-line training course in Healthcare Academy to be completed by the end of April. Abuse Reporting Audits are being conducted to make sure staff know what to report and when to report four times a day for the first seven days and then twice a day after that until 100% accuracy is reached for seven days in a row. QAA Committee met on 4/14/2021 to determine the root cause analysis (RCA) to identify the problem that resulted in the deficiency and develop interventions to prevent reoccurrence. The QAA Committee reviewed the Abuse Prevention/Vulnerable Adult Plan. Date of Completion: 4/14/2021 The correction will be monitor by: Administrator/Designee	

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F 609	Continued From page 4	F 609		

not get her pain medication. R4 stated she had hurt her arm when she fell. R4's hand, wrist and lower arm were observed and appeared bruised and swollen. R4 reported this incident happened in the mid-afternoon but was unsure of the day. R4 continued to talk about being upset with the staff member and their response to her request and not getting her needs met.

On 3/29/21, at 3:49 p.m. the facility DON and administrator were informed of R4's concerns.

R32's Admission Record printed 4/1/21, indicated R32's diagnoses included Alzheimer's disease and pain.

R32's Significant Change MDS dated 3/18/21, indicated R32 always understood others and was understood by others, was cognitively intact with no symptoms of delirium, psychosis, or behaviors and had mild symptoms of depression during the MDS assessment period. R32's MDS further indicated R32 required extensive assistance of one staff with transfers, ambulation, and toilet use, was frequently incontinent of bladder, and had frequent pain that interfered with day-to-day activities. In addition, R32 had one fall without injury since the previous MDS assessment.

R32's care plan initiated 2/8/21, indicated R32 had an alteration in cognition due to Alzheimer's and directed staff to allow R32 time to communicate her needs and wants. R32's care plan indicated R32 had an alteration in mobility and was at risk for falls and was occasionally incontinent of bladder and required assistance of one staff with toileting every 2-3 hours and as necessary. R32's care plan further indicated R32 had an alteration in mood and behavior used the

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F 609	Continued From page 5	F 609		

call light frequently, and frequently stated she was in "crisis mode" and couldn't remember anything. R32's care plan directed staff to take time to listen to R32 and to not rush tasks, approach her in a calm manner and provide her with choices as able, provide emotional support, and monitor and respond to unmet needs.

R32's progress notes dated 3/28/21, at 10:14 p.m. indicated R32 was having obsessions and being overly particular about everything staff did, and was not receptive to redirection.

R32's progress notes dated 3/29/21, at 1:06 p.m. indicated R32 was putting on her call light frequently and when staff asked her what she needed, R32 denied putting on her light, but if staff waited, she would think of something. R32 was encouraged to use her call light when she thought of something.

On 3/29/21, at 6:48 p.m. R32 was interviewed and reported some staff get sassy and walked out of her room "like that's enough of you," closed the door, then wouldn't answer her call light if she put it on again. R32 stated she just goes without what she needed. R32 stated she puts on her call light to use the bathroom, but they don't always answer it, and she has to wet her bed, or try to go herself. R32 stated she feels bad when she has to wet her bed. R32 stated she feels the staff take advantage of her because she can't remember things. R32 reported that this happens at the busiest time of the day, towards dinner time in the evening. When asked about abuse, R32 repeated that staff don't answer her light, get sassy, slam the door, and don't take care of what she needs. R32 stated has had to wet the bed, and staff will sometimes put her in a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT RUSH CITY LLC	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

(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
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way she did not normally lay, don't make her comfortable, and are snappy and rough. R32 stated it hurt her at times when they move her that way, but it was bearable pain, because she has pain all the time. R32 stated she feels like the staff don't want to answer her light. R32 was unable to identify specific staff or dates.

On 3/29/21, at 7:15 p.m. the DON was made aware of R32's concerns.

On 3/29/21, at 7:35 p.m. licensed social worker (LSW)-A stated the facility had talked to R4 and R32, and wrote up grievances for them.

A Grievance/Concern form dated 3/29/21, indicated R4 had reported she was told by staff that she put on her call light too often, but lacked the remainder of R4's concern, including not getting her needs met and feeling upset. R4's grievance form indicated LSW-A spoke with R4, and R4 had been upset when she had been on the other side of the building, in a different room. R4 recalled she had been concerned about a pill, but then could not recall details. R4's grievance documentation indicated the administrator also interviewed R4 on 3/29/21, indicated R4 stated she got her pain medications when she requested and was treated well. R4's grievance form lacked times of interviews.

A Grievance/Concern form dated 3/29/21, indicated a concern or grievance by R32 had been reported to LSW-A, and LSW-A interviewed R32. LSW-A's documentation indicated during her interview with R32, R32 reported she did not always feel safe in the facility, but when asked, was unable to provide details. R32 stated staff could be "bossy," but declined to describe staff

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	245348	A. BUILDING _____ B. WING _____	C 04/01/2021

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and to provide specific examples. R32's grievance report indicated R32 had been interviewed by the administrator a second time on 3/29/21. During the second interview, R32 reported everything was going fine, but when asked if she felt safe in the facility, she said "so-so." R32 stated she was in crisis mode and was unable to remember any details. R32 stated she was not really treated poorly, but staff could be grouchy. R32's grievance documentation lacked times of interviews.

On 3/30/21, at 9:20 am. LSW-A stated she had filled out grievances for both R4 and R32, and had viewed it as a customer service concern and had not reported either concern to the SA as potential abuse allegations. LSW-A stated she had filled out grievance forms for both residents and stated she and the administrator had interviewed both residents and viewed it as a customer service concern, so they educated staff on customer service. LSW-A stated R4 talked about when she had been on the other side of the facility and staff who had become upset with her for putting on her call light. R4 said she felt safe, but was inconsistent with her story. R4 had stated she had gotten her pain medications. LSW-A stated they were educating staff on customer service, assessing for pain and interviewing all other residents. LSW-A stated R32 had reported not feeling safe all the time, but could not remember a lot. LSW-A stated R32 said staff could be bossy, and said staff could listen and not be in such a rush. LSW-A stated R32 took a long time with cares. LSW-A stated R32 did not mention her door being slammed. LSW-A stated she had the administrator interview R32, and when asked if she felt safe in facility, R32 stated, "so-so," but was in "crisis mode" and

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could not give details. When the concerns reported by R4 and R32 on 3/29/21, were repeated to LSW-A, as R4 and R32 had expressed them, and when R32's statements of feeling unsafe, LSW-A stated she had not received that information on 3/29/21. LSW-A verified R32's statements of not always feeling safe, along with other concerns for R4 and R32, rose to the level of allegations of abuse. LSW-A verified R4's and R32's concerns should have been reported immediately to the SA.

An Incident Report Summary dated 3/30/21, indicated the facility reported R4's complaint to the SA on 3/30/21, at 10:31 a.m.

An Incident Report Summary dated 3/30/21, indicated the facility reported R32's complaint to the SA on 3/30/21, at 10:17 a.m.

On 4/1/21, at 2:29 p.m. the administrator stated the information received on 3/29/21, regarding R4's and R32's complaints were misconstrued, and did not recall receiving the information about the staff saying R4 should not put on her call light so much by who reported it, but when it was clarified by the surveyor, they reported it. The administrator stated they had interviewed both residents on 3/29/21, but neither was able to state details, so their complaints were not reported.

The facility policy Abuse Prohibition/Vulnerable Adult Plan updated 7/19, directed staff to report allegations of abuse or suspected abuse to the SA within 2 hours of forming the suspicion of abuse.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/21/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/31/2021**

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THE ESTATES AT RUSH CITY LLC	**650 BREMER AVENUE SOUTH** **RUSH CITY, MN 55069**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey The Estates at Rush City LLC was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS	K 000		

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

Electronically Signed | 04/20/2021

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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K 000	Continued From page 1 STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Estates at Rush City LLC care center is a 1-story building with a partial basement constructed in 1967 of type II(111) construction. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The facility has a licensed capacity of 45 beds and had a census of 34 at the time of the survey. The requirements of 42 CFR, Subpart 483.70(a) are NOT MET.	K 000		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility has failed to ensure that 1 of 6 emergency lights in operable condition in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 7.9.3. This deficient practice could affect residents in the event of an emergency evacuation during a power outage. Findings include: On 03/31/2021, at 2:33 p.m, during the facility tour, it was observed that the battery powered emergency light located in the lower level mechanical room B-1 was inoperable when tested at the time of the inspection. It was further verified through staff interview, by the Maintenance Supervisor, to the best of his knowledge, that that specific emergency light had been worked during the prior months 30 second monthly test but that it has not had a battery replacement for a very long time, if at all.	K 291	K291-Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Immediate corrective action: Maintenance Supervisor ran to hardware store as soon as the walk through was complete and obtained a new battery plus a few for back-ups. When he arrived back to the facility, he instantly replaced the battery in the inoperable emergency light making it in operable condition again. Date of Completion: 03/31/2021 Recurrence will be prevented by: Maintenance Supervisor will continue to test and replace the batteries every month for the time frame warranted to comply with regulations. Date of Completion: 03/31/2021	3/31/21

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K 291	Continued From page 3 This deficient condition was verified by the Maintenance Supervisor.	K 291	The correction will be monitor by: Maintenance Supervisor/Administrator	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 363		4/2/21

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K 363	Continued From page 4 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility had 1 of numerous corridor doors that did not meet the requirements of NFPA 101 "The Life Safety Code" 2012 edition, section 19.3.6.3 and 19.3.6.3.5. This deficient practice could affect 20 of 45 residents. Findings include: On 03/31/2021, at 1:24 p.m. during the facility tour, it was observed that the corridor door of the linen closet that is located in the west corridor was not equipped to positively latch into the door frame. This deficient conditions were verified by the Maintenance Supervisor.	K 363	K363- Corridor Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid bonded core wood or other material capable of resisting fire for at least 20 minutes. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. 19.3.6.3 Immediate corrective action: Safety Innovations Complete Deluxe Bi-fold Door Lock Latching mechanism is now being utilized. Staff were educated on how to properly latch them and that they must be properly latched at all time. Date of Completion: 04/02/2021 Recurrence will be prevented by: Maintenance Supervisor will do daily audits 5 times a week at different times of the day to make sure the closet remains latched and follow up if needed. Date of Completion: 04/02/2021 The correction will be monitor by: Maintenance Supervisor/Administrator	