Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 30, 2024

Administrator
Avera Granite Falls Care Center
250 Jordan Drive
Granite Falls, MN 56241

RE: CCN: 245243
Cycle Start Date: July 17, 2024

Dear Administrator:

On July 17, 2024, a survey was completed at your facility by the Minnesota Department of Health 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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"and/or an "E" tag), i.e., the plan of correction should be directed to:

Nicole Osterloh, RN, Regional Operations Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 October 17, 2024 (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 January 17, 2025 (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,

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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Administrator
Avera Granite Falls Care Center
250 Jordan Drive
Granite Falls, MN 56241

Re: State Nursing Home Licensing Orders
Event ID: ONXB11

Dear Administrator:

The above facility was surveyed on July 15, 2024 through July 17, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nicole Osterloh, RN, Regional Operations Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245243	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA GRANITE FALLS CARE CENTER	250 JORDAN DRIVE GRANITE FALLS, MN 56241

(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 Surveyor: 34083 On 7/15/24 through 7/17/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 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 Surveyor: 34083 On 7/15/24 through 7/17/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H52435460C (MN104652). 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/08/2024

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 validate substantial compliance with the regulations has been attained.	F 000		
F 557 SS=E	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Surveyor: 47497 Based on observation, interview, and record review the facility failed to ensure a homelike, dignified dining experience was provided for 1 of 4 residents (R36). This had the potential to affect all 21 residents who ate meals in the Neighborhood A dining room. Findings Include: R36's 6/26/24, annual Minimum Data Set (MDS) assessment identified she had admitted to the facility in July of 2022, her cognition was intact, and she was independent with activities of daily living (ADL's). Observation on 7/15/24 at 12:17 p.m., registered nurse (RN)-A gathered supplies and insulin pen from the medication cart near the resident dining room. RN-A walked through the dining room and approached a table that had 4 residents (R8,	F 557	On 7/15/2024 it was noted by the survey team that R22 received her insulin at the table, interview had been completed by Licensed staff that resident did not mind having her insulin at the table and was in her plan of care, however her table mates were not interviewed on their perspective or if it violated their rights. Policy on Medication Orders and Administration was updated as follows; Insulin is to be given in private areas only, preferably in the resident's room to maintain dignity and respect for those not only receiving the insulin but those at the table. Education was sent out to licensed staff via email and Nurses meeting was scheduled for July 24th, all licensed staff reviewed the updated policy. 1. Audits completed daily x 7 days beginning July 24th x 7day, then weekly x 3 months and then monthly x 6 months to	8/8/24

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F 557	Continued From page 2 R11, R36, and R22) seated and eating dinner. She told R22 that she had her insulin (a medication that is administered by injection, using a syringe, just under the skin and into the fatty layer). R22 pulled her pants downward to expose her abdomen. RN-A cleaned the site using an alcohol swab and injected the medication. A small drop of blood was visible. RN-A cleaned the blood off using the alcohol wipe and R22 pulled her pants back up. At no time did RN-A ask R22 to leave the public area to administer the insulin. Interview on 7/16/24, at 2:02 p.m., with RN-A identified that as long as it was "okay" with the resident receiving the insulin, staff can administer insulin in the dining room. It was a routine process to administer insulin injections to residents at the dining room table in the facility. She had not considered how it may affect other residents at the table and was not certain if anyone had asked them if it bothered them. She stated, "none of the other residents have mentioned any concerns, they are just used to it I guess". Interview on 7/16/24 at 2:19 p.m., with R8 identified that when she first admitted to the facility she was not "used to seeing that, but I got used to it". Nobody has ever asked her how she felt about it or if it bothered her to see a resident being administered an injection while she was eating her meals. Interview on 7/16/24 at 2:30 p.m., with R36 identified watching someone receive an injection at the table during mealtime is bothersome at times. "I wish it could be done in another way" it happens often but they (other residents at the table) do not complain because they "feel bad"	F 557	ensure compliance. 2. Audits will be reviewed monthly at QUAPI to review compliance with updated policy on Medication Orders and Administration.	

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F 557	Continued From page 3 about what the resident is going through. Nobody has ever asked her if it bothered her. R36 reports it also bothers her when the other resident receiving the injection pulls her clothing down because she is over weight and it is "not pleasant to see". She said she does not say anything because she hates to complain. Review of R36's current care plan lacked any indication that staff had asked R36 how she felt about other residents being administered injections in her presence. Interview on 7/16/24 at 9:10 a.m., with the director of nursing (DON) identified she was aware that residents receive insulin injections at the dining room table in front of other residents. She would prefer they receive their insulin injections in a private area, and identified there is a room off to the side of the dining room that staff could bring resident if they did not want to go back to their rooms. Review of the facilities November 2023, Medication Orders and Administration policy identified medications could be administered in the presence of other residents if the resident or representative agreed and is noted on care plan. There was no mention of how to ensure the rights and dignity would be maintained for other residents present during medication administration.	F 557		
F 576 SS=F	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in	F 576		8/8/24

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F 576	Continued From page 4 the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Surveyor: 34083	F 576	During resident council on 7/17/2024, it was reported to the surveyor that mail was	

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F 576	Continued From page 5 Based on interview, the facility failed to ensure mail was consistently delivered to residents on Fridays and Saturdays. This had the potential to affect all 48 residents in the facility who received personal mail, including but not limited to, 5 of 5 residents (R1, R22, R28, R30 and R38) who verbally confirmed mail was not consistently received on Fridays and Saturdays. Findings include: Resident Council was held on 7/17/24 at 10:00 a.m. with R1, R22, R28, R30 and R38 in attendance. When asked whether residents received their mail on Saturdays the 5 residents in attendance voiced they did not receive mail on Saturdays. If the administrative assistant was not in the building on Fridays, mail was also not delivered until the following Monday. The residents reported the facility had requested mail delivery be placed on hold on Saturday due to no staff available to distribute it, and to avoid it sitting from Friday/Saturday until Monday. Interview on 7/17/24 at 10:44 a.m. with the activity director reported the administrative assistant delivered the mail to residents Monday through Friday when she was working. She reported the resident council had expressed concern about security of mail delivered on Saturdays since it was delivered into a box located between the two main entrance doors. Mail in the box remained unless someone took it to a secure location or until the administrative assistant returned to work on Monday. She reported she was not aware of anyone else being responsible for mail delivery. Interview on 7/17/24 at 11:11 a.m. with the	F 576	not delivered on Saturday by five residents. Mail was put on Hold due to previous resident council meeting regarding safety and security of the mail as it is delivered into a public area in the entrance of the building. 1. Post office was called on 7/17/2024 and mail delivery was restarted on Saturdays. 2. Mail will be delivered by the nursing staff on the weekends, the medication nurse on the A Neighborhood will ensure mail is picked up and delivered in a timely manner on Fridays if Administrative Assistant is not working and on Saturdays. 3. Education has been provided to all staff and reviewed in Huddles regarding process. The business mail that is to be kept for family will stay in the Support office on the A side until Monday when family will pick up. 4. Social worker updated list to ensure all residents receive their personal mail on Friday and Saturdays. Audits will be completed by Social Worker weekly x 4 weeks beginning July 26th to ensure mail is being delivered. Mail delivery process will be scheduled for next Resident Council meeting on August 28th, 2024 to ensure all residents are aware of new process and that mail is being delivered in a timely manner. Will review in QUAPI x 3 months	

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F 576	Continued From page 6 administrative assistant identified she was responsible for retrieving and delivery of mail during the week, and if she was not working on a weekday the social services designee (SSD) delivered the mail. She reported mail delivery had been suspended on Saturdays after the resident council agreed to have it held at the post office on Saturday because they did not want packages and personal mail left unsecured in the entry. She confirmed if neither she, nor the SSD were working resident mail was not delivered, unless some other person chose to retrieve and deliver the mail. Interview on 7/17/24 1:00 p.m. with the administrator reported his expectation for mail delivery to take place up to 6 days/week unless the post office was unable to provide mail delivery. He identified it was, not acceptable to place mail delivery on hold due to the administrative assistant and/or SSD not available to retrieve and deliver mail to residents. Interview on 7/17/24 at 1:03 p.m. with the SSD reported the issue of mail delivery had been discussed at a resident council meeting with the option offered to have mail held at the post office on Saturday and delivered on Monday to avoid it sitting in the entry and not delivered until Monday when the administrative assistant or SSD returned to work. The option was addressed by the resident council president who agreed, but not presented facility wide to the residents. The SSD confirmed the facility did not have a process for mail delivery when she or the administrative assistant were not available. A policy was requested but not provided and the director of nursing (DON) identified the facility did	F 576		

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F 576	Continued From page 7 not have a policy that addressed delivery of resident mail.	F 576		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Surveyor: 34083	F 604	On 7/15/2024 it was identified that	8/8/24

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA GRANITE FALLS CARE CENTER	250 JORDAN DRIVE GRANITE FALLS, MN 56241

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F 604	Continued From page 8 Based on observation, interview, and document review, the facility failed to ensure residents were free from physical restraints for 1 of 1 resident (R14) who utilized a self-release belt as a restraint Findings include: Observation/interview on 7/15/24 at 1:09 p.m. of R14 as she sat in her wheelchair with a lap belt attached to the frame of the wheelchair and fastened in front of her lower abdomen. R14 reported she was comfortable in her chair and did not know why she had the belt on, but that staff put it on in the morning and took it off when she went to bed at night. When asked if she was able to release the belt, she stated she did not know and began fumblingly with the belt, turning it and pressing along the sides and buckle, but she was not able to press the large, square button to release the belt. She continued to fumble with the belt when nursing assistant (NA)-A entered the room and asked R14 if she needed help. NA-A attempted to direct R14 on how to release the belt, but she was not able to do so. R14 reported she knew what she was supposed to do to release the belt, but staff usually helped her to put it on and take it off. R14 reported she was not able to transfer herself and staff used the lift to transfer her. She denied any falls and reported staff were good to come when she pushed her light and needed help. Interview on 7/15/24 at 1:15 p.m. with NA-A reported since R14 had returned from her hospital stay she had needed more help and was more confused. She reported for the past couple of weeks R14 had not been able to put on or	F 604	resident R14's wheelchair had a lap belt and she was unable to release the belt. R14 was admitted to the hospital from 3/03/2024-3/20/24. No assessment was completed for restraint upon return. LTC restraint policy was not followed. During staff interview by DON, it was recognized that CNA staff had reported it as a concern to the RN coordinator, however no follow up was completed. 1. LTC Physical Restraint policy was reviewed by DON and education provided to staff on 7/15/2024. 2. Education was provided to on 7/24/2025 to Licensed staff and 7/25/2024 to the CNA staff. 3. Two-Challenge Rule was discussed in Huddles and placed on Huddle boards. The Two Challenge Rule-Empowers all team members to "stop the line" if they sense or discover an essential safety breach. When an initial safety concern is brought forward and employee feels they were not heard, please repeat your concern again. The team member being challenged must acknowledge that the concern has been heard. If the safety concern is not addressed, take a stronger course of action and use the chain of command. On 7/15/2024 the DON reviewed all residents in the facility to ensure there was no more safety breaches regarding physical restraints. R14 lap belt was removed and was placed in a tilt back chair. OT was ordered for wheelchair positioning.	

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F 604	Continued From page 9 release her lap belt and staff needed to do it for her. When asked when the belt was put on and taken off, NA-A reported it was on when she was up in her wheelchair, released and reapplied when she was toileted, or transferred to and from her wheelchair. When questioned regarding the lap belt being a restraint, NA-A responded she did not think it was a restraint and replied she thought it was for safety to keep her from falling out of her chair. NA-A identified a restraint was something used to restrain a person's arms and/or legs and she was not aware a lap belt could also be a restraint. Observation on 7/15/24 at 5:30 p.m. of R14 positioned at the livingroom table without the lap belt in place. When questioned she stated she had the belt on, and then moved her shirt to reveal her lap and stated they must have forgotten to put it back on. When asked why she needed the lap belt, R14 replied she did not know, but staff put it on in the morning when she got up and took it off when she went to bed at night. Observation on 7/16/24 at 11:09 a.m. when R14 returned from an outside activity, it was noted she was not wearing the lap belt and stated neither she nor the NA were able to get her belt on when she got up for the day. When asked about the reason she wore the lap belt she responded she did not know. Interview on 7/16/24 at 10:51 a.m. with NA-A and NA-B reported R14 moved about independently in her wheelchair, and they were not aware of any safety concerns. They reported R14 did not attempt to self-transfer and called for assistance when she needed to use the toilet. NA-B reported	F 604	Review of the December 17, 2023, policy LTC-Physical Restraint/Bed Rails Policy identified the resident/family/power of attorney must sign a consent for the use of a restraint device prior to its use. The care plan is to include: 1. Restorative Care 2. Identified risk factors and targeted interventions 3. Education to both resident/family/staff 4. Any modifications in environment 5. Supervision/monitoring by staff 6. A plan to address any identified areas of concern Both the Interdisciplinary team (IDT) and MD need to address use of the restraint/device monthly and as needed. Use was also to be reviewed at the quarterly care conferences. Restraints are to be checked by staff every 30 minutes and removed at meals and every 2 hours. Quarterly documentation of attempts for restraint reduction are to be completed with a Restraint assessment and included on MDS assessments and in the Care Area Assessments. Education was provided and review of the policy on 7/24-7/25/2024 to all nursing staff. Care Coordination will identify when a resident has a restraint, the process will reviewed as above. 1. Audits will be completed as described: -Is restraint necessary to promote safety? -OT evaluation completed for need of restraint? -MD notes in progress notes if restraint is	

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F 604	Continued From page 10 R14's belt had been removed due to not being able to self-release the belt. Both NA-A and NA-B confirmed prior to the 7/15/24 p.m. interview R14 was always wearing the lab belt when she was up in her wheelchair. NA-A and B identified they thought R14's had the lab belt due to scooting and sliding forward in her chair as she was moving about. They both reported they were not aware R14 having any recent falls or attempts to self-transfer. R14's 6/28/24 - 7/4/24 quarterly Minimum Data Set (MDS) assessment was pending at the time of review. R14's, 4/11/24 Significant change MDS following her hospitalization and completion of therapy (4/24/24) identified no restraint or devices in use. R14 had moderate cognitive impairment and identified diagnoses of morbid obesity, osteoarthritis, deformity of right foot, left skew foot deformity, degenerative arthritis, and severe scoliosis. R14's 11/16/23, Annual MDS assessment also failed to document the use of the lab belt. R14 had moderate cognitive impairment and her activities of daily living identified she had functional restrictions and had a potential for falls. Interview on 7/16/24 at 2:44 p.m. with RN-C reported she had completed R14's MDS but did not realize she had a restraint in the form of a lap belt. RN-C reported she had it for a long time, and everyone was used to seeing it. RN-C identified R14's lap belt should have been reassessed and identified in the 4/11/24 MDS as a restraint upon her hospital return, but she had not thought about it.	F 604	still appropriate? Audits and any physical restraints that are in use will be reviewed in QUAPI to ensure continued safety of residents.	

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F 604	Continued From page 11 Interview on 7/16/24 at 11:11 a.m., with RN-F identified R14 used a lap belt in her chair due to slouching or sliding forward. Review of the current physician's orders with RN-F failed to identify an order for use of a lap belt. RN-F reported he did not think R14 was able to self-release her lap belt, and he was not aware the lap belt would be a restraint if she was not able to release the belt without staff assistance. Interview and document review on 7/16/24 at 11:20 a.m. with the director of nursing (DON) reported R14's utilized a lap belt when in her wheelchair for positioning. The DON reported R14 had been provided a specialized wheelchair for mobility in the past (unable to recall dates) and was unsafe due to sliding in the chair, because it had a short seat. R14 had been able to self-release the belt initially, and she was not aware of when R14's status changed but was likely following her most recent hospitalization 3/3/24 -3/20/24. The DON reviewed the medical record and confirmed they failed to include orders for use of a seat belt and a restraint assessment had not been completed. The DON reported her expectation for the record to contain MD orders, be included in the care plan, have a restraint assessment completed and updated quarterly, in addition to a signed consent from the resident/family or healthcare power of attorney (POA). The DON confirmed R14 had utilized the lap belt when up in her wheelchair until 7/15/24 afternoon when R14 and staff had been interviewed and she was not able to demonstrate self-release of the belt. The DON identified R14's last covered Medicare day was 4/4/24 and a Significant Change MDS should have included the restraint assessment, with documentation,	F 604		

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F 604	Continued From page 12 orders and updating of the care plan. Review of the 12/17/21 LTC-Physical Restraint/Bed Rails Policy identified the purpose as standardization for use of physical restraints in Avera's Long-Term care (LTC) facilities. A physical restraint definition included manual, physical, mechanical device, material, or equipment that an individual was not able to easily remove and restricted freedom of movement or access to their body. Easily removed was defined in the policy as removed intentionally by the resident in the same manner as it had been applied. If a problem was identified the least restrictive method was to be attempted first with results documented in the record. Use of restraints required clinical justification for protection of a resident from injury to self and/or others. If found to be necessary, the health professional was to document in the medical record the assessment to include the medical condition and include the reason for the restraint as an intervention. Physician notification was required for all restraints prior to initiation and an order must be obtained for use. The order was to specify the type of restraint, when it was to be used, medical symptom requiring use, and documentation for staff to check every 30 minutes and release every 2 hours. Both residents, family/POA were required to be educated on the use of restraints with risks verses benefits reviewed. The facility was responsible to include evaluation of the restraint devise and include the medical practioner in the review. In addition, the resident/family or POA must sign a consent for the use of a restraint. Restraint use was to be evaluated monthly by the interdisciplinary team (IDT) and physician, and quarterly at care conferences. All restraints were	F 604		

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F 604	Continued From page 13 to be removed during meals unless there was a physician order or medical condition which identified the need for the restrain to remain in place.	F 604		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Surveyor: 34083	F 657	On 7/15/2024 it was identified that resident R14 had a significant change	8/8/24

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F 657	Continued From page 14 Based on observation, interview, and document review, the facility failed to revise the care plan for 1 of 1 resident (R14) who utilized a self-release belt, she was unable to release. Findings include: R14 received physician orders for a new wheelchair December of 2022 to allow for increased mobility. Occupational Therapy (OT) Evaluation and Plan of Treatment dated 1/25/23 - 3/8/23 with discharge dated 3/1/23 identified discharge instructions to include staff to encourage repositioning into upright seated position when slouching or posterior lean in chair noted. Educated patient to continue bilateral upper extremity exercises to minimize further contracture in bilateral shoulders. There was no mention of a new wheelchair or safety measures identified with use. R14 was hospitalized 3/3/24 -3/20/24 with a Urinary Tract Infection and pneumonia. Upon return assessment identified decline in cognition, strength, and mobility. R14's, 4/11/24 Significant Change Minimum Data Set (MDS), was completed following hospitalization and completion of therapy on 4/4/24. R14 had moderate cognitive impairment and identified diagnoses of morbid obesity, osteoarthritis, deformity of right foot, left skew foot deformity, degenerative arthritis, and severe scoliosis. The MDS failed to identify a seat belt type lap belt in use on her wheelchair, and a restraint assessment was not completed. R14's, 4/3/24 OT Discharge Summary Recommendations included she was	F 657	after returning from a hospital stay on 3/20/2024. Review of the Change of Condition/Assessment and Monitoring policy was reviewed. AGF must ensure that all residents receive treatment and care in accordance with professional standards of practice, CNA care sheets as changes occur. Care plan on R14 was not updated and assessments completed related to LTC Physical Restraint Policy. 1. Coaching provided to RN Coordinator on 7/17/2024 regarding Change of Condition 2. MDS Audits will continue along with IDT updates to ensure compliance of update plan of care. 3. IDT to review significant changes report to staff in 24 hour book for continued monitoring 4. Daily updates to all nursing staff on significant changes, medication changes or labs. 5. Education provided to Licensed staff on 7/25/2024 regarding Care planning and Significant Change 6. MDS Coordinator to continue quarterly Audits to ensure compliance with care plan update and CNA Care sheets. MDS Audits done weekly by RN Continue to monitor in QAPI monthly x 12 months.	

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F 657	Continued From page 15 demonstrating requirement for assistance of 1-2 staff for bed mobility, dressing, and toileting. Had an upright positioning wedge to be used on whichever side toward patient leaning when in chair. Hoyer lift for transfers and use of a standard wheelchair with lap belt for mobility in the facility. R14's current 12/21/22 care plan identified she was able to independently remove the seatbelt. Her care plan was not updated to identify her change in status following hospitalization due to no longer able to self-release seat belt when the belt was to be used and when it was to be released. The care plan also failed to include quarterly assessments for use of the lap belt, restraint assessment and review by physician and family or power of attorney for orders, and consent for use of device. Observation/interview on 7/15/24 at 1:09 p.m. as R14 sat in her wheelchair with a lap belt attached to the frame of the wheelchair and fastened in front of her lower abdomen. R14 reported she was comfortable in her chair and did not know why she had the belt on, but that staff put it on in the morning and took it off when she went to bed at night. When asked if she was able to release the belt, she stated she did not know and began fumblingly with the belt, turning it and pressing along the sides and buckle, but she was not able to press the large, square button to release the belt. She continued to fumble with the belt when nursing assistant (NA)-A entered the room and asked R14 if she needed help. NA-A attempted to direct R14 on how to release the belt, but she was not able to do so. R14 reported she knew what she was supposed to do to release the belt, but staff usually helped her to put it on and take it	F 657		

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F 657	Continued From page 16 off. R14 reported she was not able to transfer herself and staff used the lift to transfer her. She denied any falls and reported staff were good to come when she pushed her light and needed help. Observation on 7/15/24 at 5:30 p.m. of R14 positioned at the Livingroom table without the lap belt in place. When questioned she stated she had the belt on, and then moved her shirt to reveal her lap and stated they must have forgotten to put it back on. When asked why she needed the lap belt, R14 replied she did not know, but staff put it on in the morning when she got up and took it off when she went to bed at night. Interview on 7/15/24 at 1:15 p.m. with NA-A reported since R14 had returned from her hospital stay she had needed more help and was more confused. She reported for the past couple of weeks R14 had not been able to put on or release her lap belt and staff needed to do it for her. When asked when the belt was put on and taken off, NA-A reported it was on when she was up in her wheelchair, released and reapplied when she was toileted, or transferred to and from her wheelchair. When questioned regarding the lap belt being a restraint, NA-A responded she did not think it was a restraint and replied she thought it was for safety to keep her from falling out of her chair. NA-A identified a restraint was something used to restrain a person's arms and/or legs and she was not aware a lap belt could also be a restraint. Interview on 7/16/24 at 2:44 p.m. with registered nurse (RN)-C who identified she had completed the MDS assessments for R14 reported she had	F 657		

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F 657	Continued From page 17 not completed a Restraint Assessment, nor documented the use of the lab belt for R14. She reported she was so used to seeing R14 with the belt in place that she had not thought about the need for an assessment. RN-C reported she was not aware R14 was no longer able to self-release her belt, not that staff were applying and releasing the belt when needed. RN-C identified the lab belt had been in place since December 2022, and had not been included in MDS assessments as it should have been. Interview on 7/16/24 at 11:20 a.m. with the director of nursing (DON) reported R14's utilized a lap belt when in her wheelchair for positioning. and the belt had been consistently utilized since December 2022 when she had been provided a specialized wheelchair for mobility. The DON reported R14 had been able to self-release the belt initially, and she was not aware of when R14's status changed but was likely following her most recent hospitalization 3/3/24 -3/20/24. Her expectation was for the medical record to contain MD orders, be included in the care plan, have a restraint assessment completed and updated quarterly, in addition to a signed consent from the resident/family or healthcare power of attorney (POA). The DON confirmed R14 had utilized the lap belt when up in her wheelchair until 7/15/24 afternoon when R14 and staff had been interviewed and she was not able to demonstrate self-release of the belt. The DON identified the care plan failed to include any mention of the use of a lap belt, nor was there any monitoring in place. She reported the care plan should have been updated when the lap belt was initially put into use, and again following her most recent hospitalization.	F 657		

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F 657	Continued From page 18 Review of the December 17, 2023, policy LTC-Physical Restraint/Bed Rails Policy identified the resident/family/power of attorney must sign a consent for the use of a restraint device prior to its use. The care plan was to include: 1. Restorative Care 2. Identified risk factors and targeted interventions 3. Education to both resident/family/staff 4. Any modifications in environment 5. Supervision/monitoring by staff 6. A plan to address any identified areas of concern Both the Interdisciplinary team (IDT) and MD need to address use of the restraint/device monthly and as needed. Use was also to be reviewed at the quarterly care conferences. Restraints are to be checked by staff every 30 minutes and removed at meals and every 2 hours. Quarterly documentation of attempts for restraint reduction are to be completed with a Restraint assessment and included on MDS assessments and in the Care Area Assessments.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Surveyor: 47497 Based on observation, interview, and record review the facility failed to groom 1 of 1 resident (R22) to maintain their highest practicable	F 677	It was identified that resident R22 was unshaven and was not documented in the plan of care that the residents required assistance or verbal cueing. DON interviewed staff and it was reported that	8/20/24

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F 677	Continued From page 19 well-being. Findings include: R22's 7/3/24, quarterly Minimum Data Set (MDS) assessment identified R22's cognition was intact, she had diagnosis of diabetes, depression, heart disease, arthralgia (joint pain), and cataract (visual impairment). She required moderate assistance from one staff for personal hygiene and dressing. R22's current care plan identified that R22 had diagnosis that could potentially affect her ability to complete ADL's (activities of daily living). Staff were to assist her to meals and assist with daily washing. R22's care plan made no mention that staff should assist with facial grooming or shaving. Observation on 7/15/24 at 2:06 p.m., of R22 seated in her recliner in her room. She was observed to have a thick patch of facial hair on her chin, approximately 1/8 inch in length. Interview on 7/15/24 at 2:06 p.m., with R22 identified that she was aware of her facial hair but often forgets to shave. Staff do not remind her or offer to shave her, but she states, "I would love it if staff would come in and offer to shave me". She tries to remember to ask the beautician when she is getting her hair done but says she forgets. Observation on 7/16/24 at 2:42 p.m., of R22 seated in room, chin hair remained unshaven and appeared longer than the day prior. Interview on 7/16/24 at 2:43 p.m., with R22 she identified that staff had still not offered to shave	F 677	resident will often refuse to be shaved or allow assistance; however this was not documented in the residents plan of care. R22 Care plan was updated on R22 to reflect, offer resident assistance with removing facial hair and document in behaviors when resident refuses. On Admission: Residents will be asked if they are independent with removing of facial hair or if they require assistance as a part of the ADL Plan of Care. Current resident that are dependent on staff for cares, care plans reviewed and updated to include assistance with removing facial hair. Resident Care Planning Process Policy was last revised on 11/2023. Avera Granite Falls Health Care Center will develop and implement a baseline care plan within 48 hours of admission. After comprehensive assessments are complete a comprehensive person centered care plan for each resident will be developed, consistent with resident rights, that includes measurable objectives and time frames to meet a residents medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. 1. Comprehensive care plans will be completed within 7 days of admission. 2. Resident care plans will be revised as changes arise. 3. MDS Coordinator reviews Care plans and CNA care sheets with MDS schedule 4. MDS Audits are completed weekly by DON-on going, reviewed at weekly during	

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	245243	A. BUILDING _____ B. WING _____	C 07/17/2024

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F 677	Continued From page 20 her, she has not asked anyone but "would like it if someone would just come in to do it" because she forgets. Interview on 7/16/24 at 2:48 p.m., with nursing assistant (NA)-E identified that if she notices that a resident is not doing self-care, she offers to assist them. She thinks that morning staff usually assist R22 with shaving. She had not noticed that R22 had thick facial hair on her chin and stated, "I guess I hadn't paid attention." Interview on 7/16/24, at 4:00 p.m., with registered nurse (RN)-A identified that she was responsible for updating care plans, she would expect staff to offer to shave female residents who have facial hair regardless of if it is on the care plan or not. She agrees it should have been added to the care plan. A policy was requested, nothing was provided by the end of the survey.	F 677	Medicare meeting. 5. Facial hair Audits to be implemented weekly to ensure residents are being assisted with facial grooming. 6. Audits are reviewed at monthly QAPI meetings to address any trends that arise.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		8/8/24

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F 755	Continued From page 21 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Surveyor: 47497 Based on interview and document review, the facility failed to ensure insulin was administered timely for 1 of 1 resident (R27). Findings include: R27's 7/8/24, significant change Minimum Data Set (MDS) assessment identified R27's cognition was intact. She has a diagnosis of diabetes mellitus. Interview on 7/15/24, at 12:54 p.m., with R27 identified that she had not received her a.m., insulin administration until 11:00 a.m., that day and said her blood sugar was "well over 300". A different nurse approached her at around 11:30 a.m., to administer her noon insulin but R27 told	F 755	On 7/15/202 it was identified that Licensed Staff did not give R27 her prescribed insulin in a timely manner and MD was not notified or QM created. Review of Medication Variance Report Policy identifies the following; 1. Report all medication errors to the supervisor 2. Notify the provider, resident or family member of error. The provider will evaluate the order and make an assessment and provide appropriate orders regarding medications given. 3. Document nursing assessment and actions immediately following the the medication error. 4. Complete the QM in Meditech 5 Describe is your own words the	

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F 755	Continued From page 22 her she had just had insulin and it would be too close together. The nurse did not administer the insulin. R27's current administration record identified she had an order for Lispro 100 units/milliliter (ml), 2 units before meals plus a sliding scale dose (based on blood sugar levels). Interview on 7/15/24 at 5:52 p.m., with registered nurse (RN)-A identified she had approached R27 to administer her insulin at 11:30, R27 refused the insulin administration and reported to her that another nurse had just administered her morning dose. RN-A held the insulin but did not follow up with the other nurse, did not complete a medication error report, and did not contact the physician for guidance. Interview on 7/16/24 at 1:36 p.m., with RN-B identified it was a "hectic morning" she had gathered her supplies to administer R27's insulin and signed it off in the medical record, when she went to administer the insulin R27 was exercising so she left the area with the intention of returning in a few minutes, but she "forgot". RN-A returned later and administered the insulin around 10:30, she identified that she should have changed the time in the administration record but she "got side-tracked" and did not make the adjustment. RN-B did not report the late insulin administration to anyone at the facility, she did not complete a medication error report, and did not notify the physician. Interview on 7/16/24, at 4:49 p.m., with the director of nursing identified she would have expected better communication in the nursing department. She would expect nursing to notify	F 755	variance found and contributing factors. 6. Will discuss variance in IDT and review in monthly QAPI meeting. 7. Audits completed through Meditech by DON/RN Coordinators to ensure that insulin is given as directed. Audits done weekly x 3 months and then monthly x 6 months, just in time training and education provided to licensed staff beginning 7/18/2024. Policy and procedure completed at Licensed staff meeting on 7/24/2024. Medication variances are discussed during the Quality meeting monthly ongoing, trends and patterns are discussed and policies reviewed to identify and concerns to be addressed.	

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F 755	Continued From page 23 the physician for guidance and complete a medication error report. Review of the November 2023 Medication Orders Administration Policy identified medication errors would be reported and the physician will be notified. Staff will document administration of medication immediately after administration.	F 755		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: Surveyor: 34083 On 7/15/24 through 7/17/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are	2 000		

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2 000	Continued From page 1 issued, S1426. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed during the survey: H52435460C (MN104652). NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is	2 000		

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2 000	Continued From page 2 enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 385	MN Rule 4658.0200 Subp. 3 Policies Concerning Residents; Mail Subp. 3. Mail. A resident must receive mail unopened unless the resident or the resident's legal guardian, conservator, representative payee, or other person designated in writing by the resident has requested in writing that the mail be reviewed. The outgoing mail must not be censored. This MN Requirement is not met as evidenced by: Surveyor: 34083 Based on interview, the facility failed to ensure mail was consistently delivered to residents on Fridays and Saturdays. This had the potential to affect all 48 residents in the facility who received personal mail, including but not limited to, 5 of 5 residents (R1, R22, R28, R30 and R38) who verbally confirmed mail was not consistently received on Fridays and Saturdays. Findings include:	2 385	Corrected	8/8/24

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2 385	Continued From page 3 Resident Council was held on 7/17/24 at 10:00 a.m. with R1, R22, R28, R30 and R38 in attendance. When asked whether residents received their mail on Saturdays the 5 residents in attendance voiced they did not receive mail on Saturdays. If the administrative assistant was not in the building on Fridays, mail was also not delivered until the following Monday. The residents reported the facility had requested mail delivery be placed on hold on Saturday due to no staff available to distribute it, and to avoid it sitting from Friday/Saturday until Monday. Interview on 7/17/24 at 10:44 a.m. with the activity director reported the administrative assistant delivered the mail to residents Monday through Friday when she was working. She reported the resident council had expressed concern about security of mail delivered on Saturdays since it was delivered into a box located between the two main entrance doors. Mail in the box remained unless someone took it to a secure location or until the administrative assistant returned to work on Monday. She reported she was not aware of anyone else being responsible for mail delivery. Interview on 7/17/24 at 11:11 a.m. with the administrative assistant identified she was responsible for retrieving and delivery of mail during the week, and if she was not working on a weekday the social services designee (SSD) delivered the mail. She reported mail delivery had been suspended on Saturdays after the resident council agreed to have it held at the post office on Saturday because they did not want packages and personal mail left unsecured in the entry. She confirmed if neither she, nor the SSD were working resident mail was not delivered,	2 385		

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2 385	Continued From page 4 unless some other person chose to retrieve and deliver the mail. Interview on 7/17/24 1:00 p.m. with the administrator reported his expectation for mail delivery to take place up to 6 days/week unless the post office was unable to provide mail delivery. He identified it was, not acceptable to place mail delivery on hold due to the administrative assistant and/or SSD not available to retrieve and deliver mail to residents. Interview on 7/17/24 at 1:03 p.m. with the SSD reported the issue of mail delivery had been discussed at a resident council meeting with the option offered to have mail held at the post office on Saturday and delivered on Monday to avoid it sitting in the entry and not delivered until Monday when the administrative assistant or SSD returned to work. The option was addressed by the resident council president who agreed, but not presented facility wide to the residents. The SSD confirmed the facility did not have a process for mail delivery when she or the administrative assistant were not available. A policy was requested but not provided and the director of nursing (DON) identified the facility did not have a policy that addressed delivery of resident mail. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and develop a plan to ensure residents have reasonable access to personal mail, including Saturdays. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure resident(s) received personal mail,	2 385		

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2 385	Continued From page 5 including Saturdays. The results of these audits will be reviewed by the quality assessment committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 385		
2 530	MN Rule 4658.0300 Subp. 4 Use of Restraints Subp. 4. Decision to apply restraint. The decision to apply a restraint must be based on the comprehensive resident assessment. The least restrictive restraint must be used and incorporated into the comprehensive plan of care. The comprehensive plan of care must allow for progressive removal or the progressive use of less restrictive means. A nursing home must obtain an informed consent for a resident placed in a physical or chemical restraint. A physician's order must be obtained for a physical or chemical restraint which specifies the duration and circumstances under which the restraint is to be used, including the monitoring interval. Nothing in this part requires a resident to be awakened during the resident's normal sleeping hours strictly for the purpose of releasing restraints. This MN Requirement is not met as evidenced by: Surveyor: 34083 Based on observation, interview, and document review, the facility failed to ensure residents were free from physical restraints for 1 of 1 resident (R14) who utilized a self-release belt as a restraint Findings include:	2 530	Corrected	8/8/24

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2 530	Continued From page 6 Observation/interview on 7/15/24 at 1:09 p.m. of R14 as she sat in her wheelchair with a lap belt attached to the frame of the wheelchair and fastened in front of her lower abdomen. R14 reported she was comfortable in her chair and did not know why she had the belt on, but that staff put it on in the morning and took it off when she went to bed at night. When asked if she was able to release the belt, she stated she did not know and began fumblingly with the belt, turning it and pressing along the sides and buckle, but she was not able to press the large, square button to release the belt. She continued to fumble with the belt when nursing assistant (NA)-A entered the room and asked R14 if she needed help. NA-A attempted to direct R14 on how to release the belt, but she was not able to do so. R14 reported she knew what she was supposed to do to release the belt, but staff usually helped her to put it on and take it off. R14 reported she was not able to transfer herself and staff used the lift to transfer her. She denied any falls and reported staff were good to come when she pushed her light and needed help. Interview on 7/15/24 at 1:15 p.m. with NA-A reported since R14 had returned from her hospital stay she had needed more help and was more confused. She reported for the past couple of weeks R14 had not been able to put on or release her lap belt and staff needed to do it for her. When asked when the belt was put on and taken off, NA-A reported it was on when she was up in her wheelchair, released and reapplied when she was toileted, or transferred to and from her wheelchair. When questioned regarding the lap belt being a restraint, NA-A responded she did not think it was a restraint and replied she thought it was for safety to keep her from falling out of her chair. NA-A identified a restraint was something	2 530		

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2 530	Continued From page 7 used to restrain a person's arms and/or legs and she was not aware a lap belt could also be a restraint. Observation on 7/15/24 at 5:30 p.m. of R14 positioned at the livingroom table without the lap belt in place. When questioned she stated she had the belt on, and then moved her shirt to reveal her lap and stated they must have forgotten to put it back on. When asked why she needed the lap belt, R14 replied she did not know, but staff put it on in the morning when she got up and took it off when she went to bed at night. Observation on 7/16/24 at 11:09 a.m. when R14 returned from an outside activity, it was noted she was not wearing the lap belt and stated neither she nor the NA were able to get her belt on when she got up for the day. When asked about the reason she wore the lap belt she responded she did not know. Interview on 7/16/24 at 10:51 a.m. with NA-A and NA-B reported R14 moved about independently in her wheelchair, and they were not aware of any safety concerns. They reported R14 did not attempt to self-transfer and called for assistance when she needed to use the toilet. NA-B reported R14's belt had been removed due to not being able to self-release the belt. Both NA-A and NA-B confirmed prior to the 7/15/24 p.m. interview R14 was always wearing the lab belt when she was up in her wheelchair. NA-A and B identified they thought R14's had the lab belt due to scooting and sliding forward in her chair as she was moving about. They both reported they were not aware R14 having any recent falls or attempts to self-transfer.	2 530		

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(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) COMPLETE DATE
2 530	Continued From page 8 R14's 6/28/24 - 7/4/24 quarterly Minimum Data Set (MDS) assessment was pending at the time of review. R14's, 4/11/24 Significant change MDS following her hospitalization and completion of therapy (4/24/24) identified no restraint or devices in use. R14 had moderate cognitive impairment and identified diagnoses of morbid obesity, osteoarthritis, deformity of right foot, left skew foot deformity, degenerative arthritis, and severe scoliosis. R14's 11/16/23, Annual MDS assessment also failed to document the use of the lab belt. R14 had moderate cognitive impairment and her activities of daily living identified she had functional restrictions and had a potential for falls. Interview on 7/16/24 at 2:44 p.m. with RN-C reported she had completed R14's MDS but did not realize she had a restraint in the form of a lap belt. RN-C reported she had it for a long time, and everyone was used to seeing it. RN-C identified R14's lap belt should have been reassessed and identified in the 4/11/24 MDS as a restraint upon her hospital return, but she had not thought about it. Interview on 7/16/24 at 11:11 a.m., with RN-F identified R14 used a lap belt in her chair due to slouching or sliding forward. Review of the current physician's orders with RN-F failed to identify an order for use of a lap belt. RN-F reported he did not think R14 was able to self-release her lap belt, and he was not aware the lap belt would be a restraint if she was not able to release the belt without staff assistance. Interview and document review on 7/16/24 at	2 530		

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	00725	A. BUILDING: _____ B. WING _____	C 07/17/2024

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2 530	Continued From page 9 11:20 a.m. with the director of nursing (DON) reported R14's utilized a lap belt when in her wheelchair for positioning. The DON reported R14 had been provided a specialized wheelchair for mobility in the past (unable to recall dates) and was unsafe due to sliding in the chair, because it had a short seat. R14 had been able to self-release the belt initially, and she was not aware of when R14's status changed but was likely following her most recent hospitalization 3/3/24 -3/20/24. The DON reviewed the medical record and confirmed they failed to include orders for use of a seat belt and a restraint assessment had not been completed. The DON reported her expectation for the record to contain MD orders, be included in the care plan, have a restraint assessment completed and updated quarterly, in addition to a signed consent from the resident/family or healthcare power of attorney (POA). The DON confirmed R14 had utilized the lap belt when up in her wheelchair until 7/15/24 afternoon when R14 and staff had been interviewed and she was not able to demonstrate self-release of the belt. The DON identified R14's last covered Medicare day was 4/4/24 and a Significant Change MDS should have included the restraint assessment, with documentation, orders and updating of the care plan. Review of the 12/17/21 LTC-Physical Restraint/Bed Rails Policy identified the purpose as standardization for use of physical restraints in Avera's Long-Term care (LTC) facilities. A physical restraint definition included manual, physical, mechanical device, material, or equipment that an individual was not able to easily remove and restricted freedom of movement or access to their body. Easily removed was defined in the policy as removed intentionally by the resident in the same manner	2 530		

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2 530	Continued From page 10 as it had been applied. If a problem was identified the least restrictive method was to be attempted first with results documented in the record. Use of restraints required clinical justification for protection of a resident from injury to self and/or others. If found to be necessary, the health professional was to document in the medical record the assessment to include the medical condition and include the reason for the restraint as an intervention. Physician notification was required for all restraints prior to initiation and an order must be obtained for use. The order was to specify the type of restraint, when it was to be used, medical symptom requiring use, and documentation for staff to check every 30 minutes and release every 2 hours. Both residents, family/POA were required to be educated on the use of restraints with risks verses benefits reviewed. The facility was responsible to include evaluation of the restraint devise and include the medical practioner in the review. In addition, the resident/family or POA must sign a consent for the use of a restraint. Restraint use was to be evaluated monthly by the interdisciplinary team (IDT) and physician, and quarterly at care conferences. All restraints were to be removed during meals unless there was a physician order or medical condition which identified the need for the restrain to remain in place. SUGGESTED METHOD OF CORRECTION: The DON, could ensure Restranint Assessments are completed for all residnets with any restrictive device that could be considered a restraint prior to use. Those assessments should occur upon admission, quarterly, yearly, with a significant change and periodically thereafter as needed to accurately reflect and form of restraint in-use by residents. The facility could create policies and	2 530		

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2 530	Continued From page 11 procedures, educate staff on these changes, and perform environmental rounds/audits periodically to ensure resident safety from entrapment is appropriately monitored. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Thirty (21) days.	2 530		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced	21426		8/8/24

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21426	Continued From page 12 by: Surveyor: 39988 Based on interview and document review, the facility failed to complete timely tuberculosis (TB) test for 1 of 5 residents (R40). Findings include: R40's 7/16/24, patient information sheet identified admission in May 2024. R40's medical record identified R40 had a TB symptom screening form completed on 5/24/24, and a TB QuantiFERON test completed on 6/19/24, 27 days later. Interview on 7/16/24 at 3:23 p.m., with infection preventionist identified the unit support nurse completed the TB screening and placed the order for the TB QuantiFERON blood test to be completed upon admission. She revealed this should all be completed within 72 hours of admission. She also completed random audits for ensuring compliance and had been unaware that the TB QuantiFERON test had been completed approximately a month after admission. She agreed that the testing had not been completed timely. Interview on 7/16/24 at 3:40 p.m., with registered nurse (RN)-B identified she had completed R40's admission assessment. She revealed R40 had a clinic appointment on 6/4/24, (12 days after R40's TB symptom screening had been completed) and she had reminded the clinic staff to send R40 to the lab following his appointment which they did but the lab only completed a urine test and did not complete the TB QuantiFERON test. She reported she did not realize the TB test had not	21426	Corrected	

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21426	Continued From page 13 been completed until 6/19/24, at which time she made sure it had been completed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could review tuberculosis policies and procedures to ensure compliance for both residents and employees. The director of nursing and/or designee could develop a monitoring system to ensure ongoing compliance. The DON or designee could develop an auditing system and review with the facility's quality assessment and assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21585	MN Rule 4658.1325 Subp. 8 Administration of Medications; documentation Subp. 8. Documentation of administration. The name, date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized person who administered and observed the same must be recorded in the resident's clinical record. Documentation of the administration must take place following the administration of the medication. If administration of the medication was not completed as prescribed, the documentation must include the reason the administration was not completed, and the follow-up that was provided, such as notification of a registered nurse or the resident's attending physician. This MN Requirement is not met as evidenced by: Surveyor: 47497	21585	Corrected	8/8/24

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21585	Continued From page 14 Based on interview and document review, the facility failed to ensure insulin was administered timely for 1 of 1 resident (R27). Findings include: R27's 7/8/24, significant change Minimum Data Set (MDS) assessment identified R27's cognition was intact. She has a diagnosis of diabetes mellitus. Interview on 7/15/24, at 12:54 p.m., with R27 identified that she had not received her a.m., insulin administration until 11:00 a.m., that day and said her blood sugar was "well over 300". A different nurse approached her at around 11:30 a.m., to administer her noon insulin but R27 told her she had just had insulin and it would be too close together. The nurse did not administer the insulin. R27's current administration record identified she had an order for Lispro 100 units/milliliter (ml), 2 units before meals plus a sliding scale dose (based on blood sugar levels). Interview on 7/15/24 at 5:52 p.m., with registered nurse (RN)-A identified she had approached R27 to administer her insulin at 11:30, R27 refused the insulin administration and reported to her that another nurse had just administered her morning dose. RN-A held the insulin but did not follow up with the other nurse, did not complete a medication error report, and did not contact the physician for guidance. Interview on 7/16/24 at 1:36 p.m., with RN-B identified it was a "hectic morning" she had gathered her supplies to administer R27's insulin and signed it off in the medical record, when she	21585		

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21585	Continued From page 15 went to administer the insulin R27 was exercising so she left the area with the intention of returning in a few minutes, but she "forgot". RN-A returned later and administered the insulin around 10:30, she identified that she should have changed the time in the administration record but she "got side-tracked" and did not make the adjustment. RN-B did not report the late insulin administration to anyone at the facility, she did not complete a medication error report, and did not notify the physician. Interview on 7/16/24, at 4:49 p.m., with the director of nursing identified she would have expected better communication in the nursing department. She would expect nursing to notify the physician for guidance and complete a medication error report. Review of the November 2023 Medication Orders Administration Policy identified medication errors would be reported and the physician will be notified. Staff will document administration of medication immediately after administration. SUGGESTED METHOD OF CORRECTION: The administrator, DON, and consulting pharmacist could review and revise policies and procedures for appropriate medication administration and educate staff. The DON or designee, could audit medication administration and take those results to the Quality Assurance Performance Improvement (QAPI) committee for a set amount of time to determine compliance and the need for further monitoring. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21585		

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21665	Continued From page 16	21665		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Surveyor: 34083 Based on observation, interview, and record review the facility failed to ensure a homelike, dignified dining experience was provided for 1 of 4 residents (R36). This had the potential to affect all 21 residents who ate meals in the Neighborhood A dining room. Findings Include: R36's 6/26/24, annual Minimum Data Set (MDS) assessment identified she had admitted to the facility in July of 2022, her cognition was intact, and she was independent with activities of daily living (ADL's). Observation on 7/15/24 at 12:17 p.m., registered nurse (RN)-A gathered supplies and insulin pen from the medication cart near the resident dining room. RN-A walked through the dining room and approached a table that had 4 residents (R8, R11, R36, and R22) seated and eating dinner. She told R22 that she had her insulin (a medication that is administered by injection, using a syringe, just under the skin and into the fatty layer). R22 pulled her pants downward to expose her abdomen. RN-A cleaned the site using an alcohol swab and injected the medication. A small drop of blood was visible. RN-A cleaned the blood	21665	Corrected	8/8/24

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21665	Continued From page 17 off using the alcohol wipe and R22 pulled her pants back up. At no time did RN-A ask R22 to leave the public area to administer the insulin. Interview on 7/16/24, at 2:02 p.m., with RN-A identified that as long as it was "okay" with the resident receiving the insulin, staff can administer insulin in the dining room. It was a routine process to administer insulin injections to residents at the dining room table in the facility. She had not considered how it may affect other residents at the table and was not certain if anyone had asked them if it bothered them. She stated, "none of the other residents have mentioned any concerns, they are just used to it I guess". Interview on 7/16/24 at 2:19 p.m., with R8 identified that when she first admitted to the facility she was not "used to seeing that, but I got used to it". Nobody has ever asked her how she felt about it or if it bothered her to see a resident being administered an injection while she was eating her meals. Interview on 7/16/24 at 2:30 p.m., with R36 identified watching someone receive an injection at the table during mealtime is bothersome at times. "I wish it could be done in another way" it happens often but they (other residents at the table) do not complain because they "feel bad" about what the resident is going through. Nobody has ever asked her if it bothered her. R36 reports it also bothers her when the other resident receiving the injection pulls her clothing down because she is over weight and it is "not pleasant to see". She said she does not say anything because she hates to complain. Review of R36's current care plan lacked any	21665		

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21665	Continued From page 18 indication that staff had asked R36 how she felt about other residents being administered injections in her presence. Interview on 7/16/24 at 9:10 a.m., with the director of nursing (DON) identified she was aware that residents receive insulin injections at the dining room table in front of other residents. She would prefer they receive their insulin injections in a private area, and identified there is a room off to the side of the dining room that staff could bring resident if they did not want to go back to their rooms. Review of the facilities November 2023, Medication Orders and Administration policy identified medications could be administered in the presence of other residents if the resident or representative agreed and is noted on care plan. There was no mention of how to ensure the rights and dignity would be maintained for other residents present during medication administration. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of providing a safe, clean, homelike environment and identify areas where medication administration is approved when accessing parts of the body either normally covered by clothing (ex: abdomen) or if there is a potential for contamination from blood or bodily fluid. Public areas or areas secured away from residents such as a medication room should be always be avoided to provide a dignified experience for all residents whom may be affected. The DON should review and revise policies if necessary, educate staff on those policies and provide specific time-frame monitoring audits to ensure	21665		

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21665	Continued From page 19 compliance. The DON or designee should take the results of the education and audits to QAPI to ensure appropriate oversight and/or the need to continue monitoring. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21665		

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	245243	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/15/2024**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/15/2024. At the time of this survey, Avera Granite Falls Care Center 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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 FORM 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

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

Electronically Signed | 08/08/2024

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 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email 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. Avera Granite Falls Care Center was built in 2015, and is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department	K 000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA GRANITE FALLS CARE CENTER	**250 JORDAN DRIVE** **GRANITE FALLS, MN 56241**

(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
K 000	Continued From page 2 notification. The facility has a capacity of 48 beds and had a census of 48 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 226 SS=D	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.5, 7.2.4.3.1, 8.3.1.2, and 8.3.3.3. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 07/15/2024 at 12:16 PM, it was revealed by observation that the door that is a part of the labeled 2-hour fire rated wall in the maintenance office that is in the storage room was propped open using a five gallon bucket. An interview with the Environmental Services	K 226	K226: Horizontal Exits: Coaching was given by the EVS Manager to the Maintenance Dept on 7-16-24. That fire doors are to always remain closed and are not allowed to be propped open. Weekly checks by EVS manager will ensure that they will be closed and remain unobstructed.	8/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245243	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/15/2024**

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K 226	Continued From page 3 Maintenance Manager and the Maintenance Tech verified this deficient finding at the time of discovery.	K 226		
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, a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/15/2024 between 10:45 AM and 01:30 PM, it was revealed by a review of available documentation and observation that at the time of the survey the facility could not provide documentation showing that they have been testing their emergency lighting. At the time of the survey the facility did not think that they had emergency lighting, but it was discovered that there was an emergency light located in the electrical room near the generator transfer switch. An interview with the Environmental Services Maintenance Manager and the Maintenance Tech verified this deficient finding at the time of discovery.	K 291	K291: Emergency Lighting: Emergency light in the electric room added to the monthly emergency lights check list. Monthly follow up by the EVS Manager will ensure that it is being checked and documented monthly and annually. Audits will be reviewed monthly in QAPI x 12 months	8/8/24

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	245243	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/15/2024**

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K 372	Continued From page 4	K 372		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 07/15/2024 at 12:23 PM, it was revealed by observation that there were penetrations in the smoke barrier above the smoke barrier doors going into the A wing caused by an electrical conduit with low voltage fire alarm wire going through it. 2. On 07/15/2024 at 12:27 PM, it was revealed by observation that there were penetrations in the smoke barrier above the smoke barrier doors going into the B wing caused by four sections of electrical conduit not being sealed.	K 372	K372: Smoke Barrier Construction: On 8-5-24 penetrations caused by electrical conduit work above the smoke barriers on A & B wing were sealed up with red fire resistance caulking. This work was done in-house by maintenance staff.	8/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245243	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/15/2024**

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K 372	Continued From page 5 An interview with the Environmental Services Maintenance Manager and the Maintenance Tech verified these deficient finding at the time of discovery.	K 372		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2 and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/15/2024 between 10:45 AM and 01:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the fire dampers in the facility had been inspected within the last four years the last inspection of the dampers was conducted on	K 521	K521: Fire Damper Inspections: Bullet Proof mechanical services has been scheduled to inspect 137 fire dampeners. Inspection date scheduled is 8-15-24. Follow up annual check from EVS manager will ensure fire dampeners are completed within the 4-year time frame for inspections.	8/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 521	Continued From page 6 02/11/2020. An interview with the Environmental Services Maintenance Manager and the Maintenance Tech verified this deficient finding at the time of discovery.	K 521		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 12, 2024

Administrator
Avera Granite Falls Care Center
250 Jordan Drive
Granite Falls, MN 56241

RE: CCN: 245243
Cycle Start Date: July 17, 2024

Dear Administrator:

On September 3, 2024, we notified you a remedy was imposed. On August 26, 2024 and September 9, 2024, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 3, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 17, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 3, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 17, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 3, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 12, 2024

Administrator
Avera Granite Falls Care Center
250 Jordan Drive
Granite Falls, MN 56241

Re: Reinspection Results
Event ID: ONXB12

Dear Administrator:

On August 26, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 17, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us