Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 6, 2024

Administrator
The Villas At St Louis Park
7500 West 22nd Street
Saint Louis Park, MN 55426

RE: CCN: 245182
Cycle Start Date: January 26, 2024

Dear Administrator:

On February 8, 2024, we notified you a remedy was imposed. On February 20, 2024 the Minnesota Department of Health 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 January 26, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 23, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of February 8, 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 February 23, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 26, 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 Therefore, the NATCEP prohibition is rescinded.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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
February 8, 2024

Administrator
The Villas At St Louis Park LLC
7500 West 22nd Street
Saint Louis Park, MN 55426

RE: CCN: 245182
Cycle Start Date: January 26, 2024

Dear Administrator:

On January 26, 2024, 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On January 25, 2024, the situation of immediate jeopardy to potential health and safety cited at F684 was removed. However, continued non-compliance remains at the lower scope and severity of E.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 23, 2024.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 23, 2024 , (42 CFR 488.417 (b)). They will also notify

the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 23, 2024, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Villas At St Louis Park LLC is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective January 26, 2024. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 26, 2024. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

If you have not achieved substantial compliance by February 23, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Villas At St Louis Park LLC will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 23, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard

quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Annette Winters, Rapid Response Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 26, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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://forms.web.health.state.mn.us/form/NHDisputeResolution

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 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

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

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Electronically delivered

February 8, 2024

Administrator
The Villas At St Louis Park LLC
7500 West 22nd Street
Saint Louis Park, MN 55426

Re: Event ID: DCMW11

Dear Administrator:

The above facility survey was completed on January 26, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
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
	245182	A. BUILDING _____ B. WING _____	C 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT ST LOUIS PARK	7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426

(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
F 000	INITIAL COMMENTS On 1/22/24 through 1/26/24, a standard abbreviated survey was conducted at your facility. 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 H51828956C (MN100059) and H51829024C (MN100109) with a deficiency issued at F684. Deficient practice was identified related to incidental findings at F609 and F610. The survey resulted in an Immediate Jeopardy (IJ) at F684 when the facility failed to provide ongoing monitoring, comprehensive assessment, and care planning, and needed care consistent with professional standards of practice, facility policy, and provider orders resulting in risk of serious harm, injury, impairment, or death related to complications of coronavirus disease 2019 (COVID-19) infections to 5 of 5 residents (R1, R4, R6, R7, and R8). The IJ began on 1/3/2024 and the immediacy was removed on 1/25/2024. The above findings constituted substandard quality of care and an extended survey was conducted from 1/25/24 to 1/26/23. 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.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/12/2024

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 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 609	R2s alleged abuse allegation was	2/14/24

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F 609	Continued From page 2 failed to immediately report, within two hours, an allegation of employee to resident abuse to the State Agency (SA) for 1 of 1 (R2) resident who reported an allegation of physical abuse in the facility. Findings include: R2's Minimum Data Set (MDS) dated 12/6/23, indicated R2 was admitted 3/30/23 with diagnoses including debility, muscle weakness, heart failure, anemia (low amount of healthy red blood cells), hypertension, diabetes, atrial fibrillation, and coronary artery disease. R2 required maximum assistance with mobility in bed and toileting cares, was dependent on staff for transfers, utilized a wheelchair, and was frequently incontinent of bowel and bladder. R2's last Brief Interview for Mental Status score from MDS dated 9/19/23, indicated intact cognition with score of 14. A Police report dated 1/15/24 at 4:01 p.m., indicated the reporting officer spoke with the administrator on 1/15/24. The administrator advised the officer they spoke with R2 the same day and learned R2 reported being hit by a nurse the previous night. In an interview on 1/22/24 at 11:41 a.m., R2 stated on Sunday evening, 1/14/24, nurse aide (NA)-A and an unidentified nurse aide provided hygiene cares. During cares, NA-A rolled R2 to the right facing the wall next to the bed and hit R2 in the back of the head and pushed R2's head against the wall. R2 stated this behavior was criminal and was abuse and they spoke to the administrator of the facility and reported the event in the morning on Monday 1/15/24. R2 stated	F 609	reported to the state agency on 2/12/2024 All residents are at risk for abuse Administrator was educated by regional director of operations that all abuse allegations must be reported to the state agency on 2/12/2024 The DON/Admin/designee will be responsible for auditing allegations of abuse to ensure they are reported to the state agency 5x/week for 2 weeks, then 3x/week for 1 week, then 2X/week. Audits will be reviewed through the monthly QAPI process for monitoring of trends, patterns, and recommendations for continuation.	

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F 609	Continued From page 3	F 609		

they went to a medical appointment after speaking to the administrator, informed a police officer at the hospital, and filed a police report regarding the assault allegation.

In an interview on 1/22/24 at 11:52 a.m., MDS coordinator (MC) stated R2 has a history of reporting mistreatment or abuse. MC indicated the facility self-reported what R2 said a few times and the SA came to investigate, MC thought the results were unsubstantiated. MC stated they had not worked the last few weeks and were unaware of R2's recent allegation of abuse prior to conversation with R2 on 1/22/24.

In an interview on 1/22/24 at 12:48 p.m., the administrator stated R2 told them on the morning of 1/15/24 NA-A had hit R2 on the head the previous evening. The administrator stated NA-A and licensed practical nurse LPN-A who worked on R2's unit that evening were both at the facility working on the morning of 1/15/24. The administrator indicated they spoke to NA-A and LPN-A within five minutes of speaking to R2 and unsubstantiated the allegation because NA-A and LPN-A reported no one went into R2's room alone and nothing happened. R2 was on buddy cares due to past allegations and NA's were to provide all cares in pairs and not alone. The administrator reported R2 had a similar abuse allegation in August where everything was the same except R2 reported an NA twisted their arm instead of hitting their head. The allegation was reported and investigated by the SA and unsubstantiated. R2 was on buddy cares and NA-A and LPN-A stated nothing happened so the allegation was treated as a resident behavior and grievance which has not been filed yet. R2 has seen providers with the Associated Clinic of

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F 609	Continued From page 4 Psychology (ACP) quite regularly and we are going to have ACP see R2 because we are approaching it as more of a behavior and having R2 see psychology. The administrator stated that per the facility policy (Abuse Prohibition/Vulnerable Adult Policy), they have two hours to report allegations of abuse but did not report R2's allegation because they were able to unsubstantiate it immediately and abuse did not occur. The facility failed to report R2's allegation of employee to resident abuse to the SA. Review of recent grievances provided by the facility did not include the 1/15/24 incident and the administrator stated that they were currently putting the grievance into the facility's reporting system. In an interview on 1/23/24 at 8:28 a.m., LPN-B stated R2 reported two NAs changed them and NA-A pushed their head. R2 reported it to LPN-B on Monday 1/15/24 or Friday 1/19/24, LPN-B was unsure. LPN-B reported the allegation to the assistant director of nursing (ADON) immediately and ADON already knew about the allegation. In an interview on 1/23/24 at 11:56 a.m., ADON stated R2 told the administrator about the allegation of abuse on 1/15/24. The administrator interviewed staff and believed it was unsubstantiated. The administrator usually does the reporting and fills out the report, but all staff are mandated reporters. In an interview on 1/23/24 at 2:04 p.m., the administrator stated R2 made a statement that a staff member hit them and a staff member hitting a resident would be considered abuse. It was an allegation of physical abuse. I was immediately able to discredit it based on staff following the	F 609		

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F 609	Continued From page 5 plan of care with buddy cares and R2 has a history of these allegations, so we put it in as a grievance and are following up with R2's mental health care provider because there was nothing to report to the SA. R2's statement was a statement about customer service and bedside manner. Facility policy titled Abuse Prohibition/Vulnerable Adult Policy dated 8/2023, directs "to promptly report, document, and investigate all incidents of alleged or suspected abuse/neglect. Incidents that must be reported to MDH [Minnesota Department of Health] include abuse - abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Suspected abuse shall be reported to OHFC online reporting process not later than 2 hours after forming the suspicion of abuse. Five-day follow-up reports are still required. The Director of Nursing, Social Worker, and other department directors will be notified as needed. If the alleged perpetrator is a supervisor or department head, the person(s) will notify the alleged perpetrator's supervisor or the Vice President of Social	F 609		

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	245182	A. BUILDING _____ B. WING _____	C 01/26/2024

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F 609	Continued From page 6 Services & Behavioral Health. Notify the Minnesota Department of Health (MDH) on the notification website immediately after discovery of incident."	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to complete a thorough investigation of allegations of employee to resident abuse for 1 of 1 resident (R2) who reported an allegation of abuse. Findings include: R2's Minimum Data Set (MDS) dated 12/6/23, indicated R2 was admitted 3/30/23 with diagnoses including debility, muscle weakness,	F 610	R2s alleged abuse allegation was reported to the state agency on 2/12/2024 and a statement from NA B was obtained on 1/26/2024 All residents are at risk for abuse. Administrator was educated by regional director of operations that all abuse allegations must be properly investigated that include statements from staff and other residents on 2/12/2024 The DON/Admin/designee will be	2/14/24

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F 610	Continued From page 7 heart failure, anemia, hypertension, diabetes, atrial fibrillation, and coronary artery disease. R2 required maximum assistance with mobility in bed and toileting care, was dependent on staff for transfers, utilized a wheelchair, and was frequently incontinent of bowel and bladder. R2's last Brief Interview for Mental Status score from MDS dated 9/19/23, indicated intact cognition with score of 14. In an interview on 1/22/24 at 11:41 a.m., R2 stated on Sunday evening, 1/14/24, at approximately 7:30 p.m., nurse aide (NA)-A and an unidentified NA provided hygiene cares. During cares, NA-A rolled R2 to the right facing the wall next to the bed, hit R2 in the back of the head, and pushed R2's head against the wall. R2 stated this behavior was criminal and was abuse and they reported it to the facility's administrator on Monday morning 1/15/24. R2 then went to a medical appointment, informed a police officer at the hospital, and filed a police report regarding the assault allegation. Police report dated 1/15/24 at 4:01 p.m., indicated the reporting officer spoke with the administrator on 1/15/24. The administrator advised the officer they spoke with R2 that morning and learned R2 reported being hit by a nurse the previous night. The administrator stated R2 is not allowed to be alone with a nurse in the room because R2 has made multiple false claims of abuse in the past. The report noted the administrator spoke with the second nursing staff member in R2's room with NA-A the staff member did not observe any abuse of R2, which then ended the investigation into the allegation. In an interview on 1/22/24 at 12:48 p.m., the	F 610	responsible for auditing allegations of abuse to ensure a thorough investigation occurs 5x/week for 2 weeks, then 3x/week for 1 week, then 2X/week. Audits will be reviewed through the monthly QAPI process for monitoring of trends, patterns, and recommendations for continuation.	

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F 610	Continued From page 8 administrator stated on the morning of 1/15/24 R2 told them NA-A hit R2 on the head the previous evening. The nursing staff on R2's unit during the alleged abuse were NA-A, NA-B, and LPN-A. The administrator interviewed NA-A and LPN-A in person five minutes after speaking to R2 and immediately unsubstantiated the allegation because both stated nothing happened and no one entered R2's room alone. The administrator stated R2 was on buddy cares and all cares were to be done by two staff members and NA-A and NA-B followed the plan of care by providing cares together, were both able to attest no abuse occurred, and provided written statements. NA-A was also taken off R2's unit at this time and re-assigned. The administrator stated NA-A reported R2 said their head was hit during peri-cares but that did not happen. R2 reported his face hurt to the administrator and the administrator and director of nursing (DON) looked at R2's face and noted no signs of injury. The administrator stated they spoke to the reporting police officer on the evening of 1/15/24, informed the officer the investigation unsubstantiated the allegation and it would be approached as a resident behavior. The administrator stated R2 had a history of similar allegations, and the report was considered a resident behavior and a grievance. The grievance was being filed by the administrator at the time of interview. Review of the R2's grievance report dated 1/15/24 included a summary of investigation which indicated the incident did not occur. R2 has a history of making false allegations against staff who are not of the same race. On 8/22/2023 R2 accused two other staff of similar allegations.	F 610		

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F 610	Continued From page 9 Summary of findings noted the incident did not occur and summary of actions taken noted R2 to follow up with their psychologist (mental healthcare). In an interview on 1/22/24 at 1:46 p.m., R2 stated the administrator said they would investigate the allegation after R2 reported it, but R2 had not heard anything since then. In an interview on 1/23/24 at 9:03 a.m., LPN-A confirmed they were the nurse and NA-A, and NA-B were the NAs on R2's unit the evening of 1/14/24. LPN-A stated they saw NA-A and NA-B enter other resident rooms together that evening but did not see NA-A and NA-B enter R2's room. LPN-A stated they spoke to the administrator on the morning of 1/15/24 and wrote a statement. LPN-A's written statement, undated, notes no incident was observed or reported to them on 1/14/24 and they saw NA-A and NA-B do cares together. It does not indicate LPN-A observed NA-A and NA-B enter R2's room together. In an interview on 1/23/24 at 9:32 a.m., NA-B stated they entered R2's room with NA-A on 1/14/24 to provide cares. NA-B had not heard about R2's report and had not spoken to supervisors or management about the alleged abuse. In an interview on 1/23/14 at 10:57 a.m., NA-A stated on 1/14/24, they provided cares to R2 with NA-B and R2 said they hit R2's head. NA-A confirmed they worked the next morning on 1/15/24 and spoke to the administrator about the allegation and provided a written statement.	F 610		

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F 610	Continued From page 10 NA-A's written statement dated 1/16/24, notes NA-A was with another NA in R2's room changing R2, R2 said they hit their head, and what R2 said was not true. The facility's investigation was requested and no other written statements from staff or residents were provided. In an interview on 1/23/24 at 11:56 a.m., assistant director of nursing (ADON) stated R2 spoke to the administrator on 1/15/24 who started an investigation, interviewed the two NAs in R2's room and nurse on shift, believed it unsubstantiated, and moved NA-A to a different unit. ADON was not aware of anything else done in the investigation. ADON indicated staff education about abuse was not provided and audits or observations of care were not done. ADON reported they assisted an NA with R2's cares on 1/15/24 but did not do formal observations of care. ADON stated they expected a thorough investigation of an abuse allegation to include staff interviews, interviews of resident(s) involved, and interviews of other residents. In an interview on 1/23/24 at 2:04 p.m., the administrator stated they spoke to LPN-A and NA-A and left NA-B a voicemail, but never spoke to NA-B about R2's report. With LPN-A and NA-A's statements, the administrator stated they were able to collaborate [sic] the two stories that no one went in R2's room alone. The administrator stated R2 made an allegation of physical abuse and R2 has a history of these allegations, so it was put in as a grievance and there will be follow up with R2's psychology providers. The administrator stated they did not complete a formal investigation, perform audits, complete	F 610		

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F 610	Continued From page 11	F 610		

observations, or provide staff education because the allegation was immediately discredited, and staff followed R2's plan of care. They did not speak to other residents as part of an investigation because the two staff were the witnesses and said it did not happen. The administrator stated they ruled it out immediately, so did not need to investigate further.

Record review of the facility's requested investigation consisted of Statements of Reported Incidents from NA-A and LPN-A and R2's Grievance Summary. It did not include documentation of interviews with NA-B, R2, R2's roommate, other residents, or other staff members. It did not include documentation of a skin inspection of R2 performed after the reported allegation, audits, or observations of care. Review of R2's medical record revealed no further documentation of an investigation related to the incident.

Facility policy titled Abuse Prohibition/Vulnerable Adult Policy dated 8/2023, directs "to promptly report, document, and investigate all incidents of alleged or suspected abuse/neglect." The Investigation/Protection section includes:
"1. Investigation will begin immediately in accordance with Federal Law.
2. Staff will take immediate and appropriate actions to prevent further abuse, neglect, exploitation,
and mistreatment from occurring while the investigation is in progress.
3. The facility's Investigation Team will review all Incident Reports regarding residents including those that indicate an injury of unknown origin, abuse, neglect, misappropriation of resident. property, or involuntary seclusion no later than

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F 610	Continued From page 12 the next working day following the incident. 4. The Investigation Team will determine if further investigation is needed. 5. The designated person will notify the designated agency in the state as soon as possible after reviewing the Vulnerable Adult Report. The designated person will also complete and submit any reports required by the State. 6. The Investigation Team will continue the investigation. Investigation may include interviewing staff, residents, or other witnesses to the incident. 7. Corrective action based on the investigation will be completed (e.g., change of procedure, training, discipline, or discharge of staff, etc.). 8. All documentation will be kept in a confidential file in the facility in accordance with State Law. A summary which identifies trends or patterns will be forwarded to the QAPI committee at least quarterly. 9. Administration or other designated staff will report the results of all investigations to the State Survey and Certification Agency and other officials in accordance with State Law, and within five (5) working days of the incident. 10. Social Services and other staff, as appropriate, will provide ongoing support and counseling to the residents and family as needed. 11. The facility will provide proper follow up communication related to the incident across all shifts and to practitioners and resident representatives as applicable."	F 610		
F 684 SS=J	Quality of Care	F 684		2/14/24

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F 684	Continued From page 13 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide ongoing monitoring, comprehensive assessment, and care planning, and needed care consistent with professional standards of practice, facility policy, and provider orders resulting in risk of serious illness or death related to complications of coronavirus disease 2019 (COVID-19) infections to 1 of 5 residents (R1) identified in Immediate Jeopardy. In addition to the resident in immediate jeopardy, the facility failed to update policies and procedures for comprehensive assessment, monitoring, developing, and revising person-centered care plans, and implement consistent interventions in accordance with professional standards of practice for all respiratory illnesses resulting in no actual harm with potential for more than minimal harm that is not immediate jeopardy for 4 out of 4 residents (R4, R6, R7, R8). The immediate jeopardy (IJ) began on 1/3/24 when R1 tested positive for COVID-19 and ongoing monitoring, comprehensive assessment, and care planning, and needed care was not provided for R1 and was identified on 1/24/24. The administrator, associate administrator,	F 684	R1 discharge from the facility on 1/8/2024 and no further action can be taken. R4, R6, R7 and R8 orders were reviewed on 1/24/2024 to ensure nursing batch orders were entered for COVID-19 Monitoring, which include a skilled note every shift, this is our respiratory assessment that includes SOB and lung sounds, and the other batch order is for vital sign monitoring. Vital sign monitoring includes temp, pulse, blood pressure, O2 stats, and respirations. R4, R6, R7 and R8 care plans were reviewed and updated to include a section for COVID-19 Residents who have an active dx of COVID-19 or other respiratory illness were reviewed to ensure batch orders were entered for monitoring, including vital signs and CPs were reviewed and updated as appropriate on 1/24/2023. Facilities COVID-19, pneumonia, influenza , and change of condition policy were reviewed and revised as necessary on 2/6/2024.	

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F 684	Continued From page 14 director of nursing, and regional nurse consultant were notified of the IJ at 6:10 p.m. on 1/24/24. The IJ was removed on 1/25/24, but noncompliance remained at the lower scope and severity level E, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: The facility's Covid Policy dated 9/26/23, included: "Management After Identification ... Monitoring of Residents: Regular monitoring of resident condition who test positive (VS [vital signs], etc.) should occur on each shift at a minimum in order to closely monitor resident condition and help determine when resident can be removed from isolation." R1's quarterly Minimum Data Set (MDS) dated 11/15/23, indicated R1 was admitted to the facility on 8/18/23 with diagnoses including Parkinson's disease, dementia, diabetes, Bell's Palsy (one-sided facial weakness) hypertension (high blood pressure), and depression. R1 had a Brief Interview for Mental Status (BIMS) score of eight indicating moderate cognitive impairment, was independent with toileting, transfers, and walking, utilized a wheelchair, was frequently incontinent of bowel and bladder, and needed set-up or clean-up assistance with eating. R1's care plan last dated 12/1/23, was not updated and did not include any focus or interventions related to R1's COVID-19 diagnosis. A progress note dated 1/3/24 at 2:41 p.m., indicated R1 tested positive for COVID-19 and	F 684	nurse leadership were educated on entering COVID-19/respiratory illness nurse batch orders and updated the residents care plan as applicable as they are alerted that a resident tested positive for COVID-19/respiratory illness on 1/24/2024. All Nurses were educated to follow orders for COVID-19 monitoring or respiratory illness monitoring , including obtaining vitals every shift and updated the provider on any change of condition and/or abnormal results The DON/Admin/designee will be responsible for daily audits for 60 days to ensure monitoring orders for residents with COVID- 19 and/or respiratory illnesses are being followed. DON and NHA are responsible for integrating the review through the QAPI process for monitoring of trends, patterns, and recommendations for continuation.	

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F 684	Continued From page 15 R1's provider and family were updated. R1's provider order dated 1/3/24, indicated R1 was prescribed a five-day course of Paxlovid (an antiviral medication used to treat mild-to-moderate COVID-19 for adults at high risk of disease progression). R1's treatment administration record (TAR), progress notes, and vital sign record from 1/3/24 to 1/7/24 did not include documentation of vital signs or monitoring of R1's COVID-19. R1's medication administration record (MAR) dated the month of January 2024, indicated R1 refused to take his morning dose of Paxlovid on 1/8/24 as prescribed. A progress note by licensed practical nurse (LPN)-D dated 1/8/24 at 5:36 p.m., indicated during report at the start of their evening shift (2:00 p.m. to 10:00 p.m.) LPN-D was told R1 was not doing well, and the provider and family had been updated. LPN-D documented R1's vital signs, which were a higher-than-normal, respiratory rate (RR) (breaths per minute) of 24, oxygen saturation level (O2 sat) (the amount of oxygen circulating in a person's blood) of 96%, and a heart rate (HR) (heart beats per minute) of 76. The note indicated LPN-D called the on-call provider, nurse practitioner (NP)-A, who ordered labs (blood work), pushing fluids (encouraging fluid intake), and vital sign checks every shift. R1's provider orders from NP-A dated 1/8/24, included labs and monitoring vital signs every shift for COVID-19 for three days including oxygen saturation levels. The faxed paper orders noted an electronic signature from NP-A at 3:37	F 684		

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F 684	Continued From page 16 p.m. and fax machine receipt time stamp at 1:37 p.m. Pacific Standard Time, equivalent to 3:37 p.m. Central Standard Time (the time zone from which the fax was sent and received). R1's vital signs record dated 1/8/24 at 6:30 p.m. indicated R1's temperature was 98 degrees Fahrenheit, and his blood pressure was 95/56. A progress note by LPN-D dated 1/8/24 at 9:58 p.m., noted at 7:11 p.m. they checked on R1 and found him unresponsive and pulseless and confirmed his death at 7:30 p.m. R1's death certificate titled Minnesota Documentation of Death indicated R1 died on 1/8/24 at 7:30 p.m. at 76 years old. Causes of death included primary causes of dementia and cerebrovascular disease (conditions affecting blood flow to the brain) with COVID-19 listed under other significant conditions contributing to death. In an interview on 1/23/24 at 8:28 a.m., LPN-B stated R1 had been gradually declining from baseline since admission. R1 used to wheel themselves around in a wheelchair, transfer themselves, and have a good appetite. Over time R1 had stayed in bed more, was more lethargic and less communicative, did not want to eat or drink as much, and declined overall. In an interview on 1/23/24 at 9:03 a.m., LPN-A stated R1 was independent with minimal assistance needed on admission and walked with a walker at times. As time went by, he declined and his Parkinson's seemed to get worse with increased shaking, he could not feed himself and someone fed him, he slept most of the time or sat	F 684		

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F 684	Continued From page 17 in his wheelchair and needed staff assistance of one to get up. In an interview on 1/23/24 at 12:57 p.m., NP-A stated she first found out R1 was diagnosed with COVID-19 when contacted by facility staff on 1/8/24. The Paxlovid must have been prescribed by the on-call provider contacted on 1/3/24 when R1 tested positive. NP-A stated for a resident with COVID-19 or another respiratory illness like pneumonia or influenza she would expect vital signs to be taken at least every shift, residents to be monitored, and to be notified right away if there was any worsening of symptoms. NP-A indicated she believed the facility's orders for COVID-19 precautions included taking vital signs every shift and thought the facility did vital signs every shift for residents with either COVID-19 or another respiratory illness. In an interview on 1/24/24 at 4:58 p.m., LPN-B stated she was the day shift nurse on R1's unit on 1/8/24. LPN-B stated on 1/8/24, she believed R1 was not eating, did not want to eat breakfast and did not want lunch if she remembered correctly, and R1 refused a meal. LPN-B stated R1 seemed sleepy and lethargic, but not more so than what had been his normal for about the last week since his diagnosis with COVID-19 on 1/3/24. LPN-B did not remember what she told oncoming nurse LPN-D during report, but thought she said to keep an eye on R1. LPN-B stated someone could have called the provider during the day about R1's clinical condition, but she did not remember calling a provider about R1 on 1/8/24. In an interview on 1/24/24 at 5:22 p.m., LPN-D stated she checked on R1 after receiving report and took his vital signs because she was told in	F 684		

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	245182	A. BUILDING _____ B. WING _____	C 01/26/2024

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F 684	Continued From page 18 report that R1 had COVID-19 and was not doing well. LPN-D heard R1 did not take his medications that morning because he had difficulty swallowing the pills, so they were held (not administered). LPN-D stated she contacted the on-call provider because of R1's increased RR and NP-A sent orders for labs and vital sign checks. In an interview on 1/25/24 at 11:55 a.m., NP-A stated a nurse called her on 1/8/24 but could not recall what time the facility called and was unable to locate documentation of the time of the call. NP-A stated the call could have been around noon, but she believes she sent the orders for labs and vitals electronically right away after the call and stated the orders were electronically signed at 3:37 p.m. on 1/8/24. NP-A indicated she wanted staff to get lab work, do closer monitoring of vital signs, and push fluids to further assess R1's condition before determining if transfer to a hospital for treatment was appropriate. In an interview on 1/24/24 at 9:01 a.m., director of nursing (DON) stated for residents with COVID-19 staff put in a batch of orders including monitoring of O2 sat, respirations, and temperature that every shift is supposed to do and do any time there is a change in a resident's condition. The facility policy for monitoring is regular monitoring of resident condition including vital signs every shift at a minimum. For residents with a respiratory illness like influenza, pneumonia, or respiratory syncytial virus staff should be looking at vital signs every shift because they are looking for a change in condition. The DON stated the facility's standard for COVID-19 vital signs monitoring order did not adhere to facility policy or professional standards	F 684		

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F 684	Continued From page 19 of practice because it only included RR, O2 sat, and temperature and did not include HR or BP. The DON stated R1 tested positive for COVID-19 on 1/3/24 and his vital signs were monitored once during his illness, on 1/8/24, the day he was found deceased. The DON stated this does not meet her expectations and it appears the facility was not monitoring R1 which does not follow facility policy or professional standards of practice. The DON stated staff would not have been able to notice a change in condition or identify when R1's condition changed due to lack of monitoring. DON stated there is nothing on R1's care plan related to COVID-19. R4's MDS dated 11/28/23, indicated R4 was admitted on 1/14/22 with diagnoses including hemiplegia (paralysis on one side of the body) affecting the right dominant side after a stroke, stroke, Alzheimer's disease, aphasia (loss of ability to understand or express communication), hypertension, hyperlipidemia (high cholesterol), malnutrition, and dysphagia (difficulty swallowing). R4 had a BIMS score of zero indicating severe cognitive impairment. R4 was dependent on staff for mobility in bed and wheelchair, transfers, bathing, toileting hygiene, and was always incontinent of bowel and bladder. R4's care plan last dated 12/10/23 included a focus on potential risk for exposure to the virus causing COVID-19 due to residing in a congregate living facility, co-morbid conditions, advanced age, and dependency on caregiver assistance. It did not include a focus or interventions related to R4's COVID-19 diagnosis. A progress note dated 1/21/24 at 10:33 a.m., indicated R4 tested positive for COVID-19. A	F 684		

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F 684	Continued From page 20 second progress note at 10:43 a.m., indicated provider and family were updated and the provider was faxing over new orders. R4's provider orders dated 1/21/24, indicated prescription of a five-day course of Paxlovid to treat COVID-19 and COVID-19 positive monitoring including check temperature, O2 sat, and RR every four hours. A provider note dated 1/22/24, indicated R4 was at high risk for complications related to COVID-19. The documented treatment plan included monitoring R4's vital signs every shift with instruction to call provider if O2 sat was less than 90% or resident had a fever. R4's vital sign record included RR documented once on 1/21/24 and once on 1/23/24. O2 sat and temperature were documented twice on 1/21/24, once on 1/22/24, and twice on 1/23/24. HR and BP were documented once on 1/21/24 and once on 1/23/24. A nursing progress note dated 1/22/24 at 2:28 p.m., indicated the writer assessed R4's vital signs including BP, HR, and RR. No other recorded vital signs were noted on R4's MAR, TAR, progress notes, or vital sign record between 1/21/24 and 1/23/24. In an interview on 1/24/24 at 9:01 a.m., The DON stated R4's O2 sat had not been monitored every shift and the facility policy for monitoring was not being followed. The DON noted they did not see anything on R4's care plan related to COVID-19 except the risk for exposure to COVID-19. R6's MDS dated 11/17/23, indicated R6 was admitted 11/10/23 with diagnoses including acute and subacute hepatic failure (liver failure),	F 684		

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F 684	Continued From page 21 alcoholic liver cirrhosis with ascites (alcohol-induced liver disease with abdominal fluid build-up), hyponatremia (low sodium level in the blood), malnutrition, depression, portal hypertension (high blood pressure in the major vein leading to the liver), muscle weakness, latent tuberculosis (tuberculosis bacteria in the body without symptoms of tuberculosis), and a thyroid disorder. R6 spoke Spanish, had some difficulty making themselves understood and understanding others, and had a BIMS score of nine indicating moderate cognitive impairment. R6 required supervisory assistance with transfers, ambulation, and toileting. A progress note dated 1/14/24 at 2:08 p.m., indicated R6 tested positive for COVID-19 and family and on-call provider were contacted. R6's provider orders dated 1/14/24, indicated prescription of a five-day course of Molnupiravir (an antiviral medication used to treat mild-to-moderate COVID-19 for adults at high risk of disease progression) and COVID-19 monitoring including check temperature, O2 sat, and RR every four hours ending 1/24/24. R6's care plan interventions last dated 1/15/24, included COVID-19 isolation precautions of infection control precautions per protocol, sign on resident's door, and treatment for current per order. R6's care plan did not include other interventions related to his COVID-19 infection. R6's vital sign record, MAR, TAR, and progress notes included RR, O2 sat, and temperature taken at least once per shift between 1/14/24 and 1/23/24. R6's HR and BP were documented once on 1/14/24 through 1/16/24, zero times on	F 684		

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F 684	Continued From page 22 1/17/24, twice on 1/18/24, once on 1/19/24, twice on 1/20/24 through 1/22/24, and once on 1/23/24. In an interview on 1/24/24 at 9:01 a.m., The DON stated R6's care plan included isolation precautions related to COVID-19, but no other interventions related to R6's COVID-19 diagnosis. She would not describe the care plan as individualized related to COVID-19. The DON stated professional standards of practice for a set of vital signs include BP, HR, temperature, RR, and O2 sat, and facility policy directed vital signs be monitored every shift for residents with COVID-19. The DON noted R6's vital signs were not monitored per facility policy and professional standards of practice and nursing staff were not monitoring him for a change in condition because there was not enough vital sign data to do so. R7's MDS dated 11/30/23, indicated R7 was admitted 3/17/23 with diagnoses including acute on chronic diastolic heart failure (an episode of worsened chronic heart failure), anemia, rheumatoid arthritis, acute and chronic respiratory failure with hypoxia (a condition where the respiratory system cannot provide enough oxygen to the body), and used supplemental oxygen. R7 had a BIMS score of 12 indicating moderate cognitive impairment, and was independent with toileting, ambulation, and transfers. R7's care plan last dated 12/10/23, did not include any focus or interventions related to R7's COVID-19 diagnosis. A progress note dated 1/17/24 at 11:00 a.m., indicated R7 tested positive for COVID-19. A provider note dated 1/17/24, indicated R7 was	F 684		

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F 684	Continued From page 23 at high risk for complications related to COVID-19. The treatment plan included prescription of Molnupiravir (an antiviral medication used to treat mild-to-moderate COVID-19 for adults at high risk of disease progression) for five days and instruction to monitor vital signs every shift and call provider if O2 sat was less than 90% or resident had a fever. R7's provider order dated 1/17/24 indicated COVID-19 positive monitoring including check temperature, O2 sat, and RR every four hours through 1/27/24. R7's vital sign record, MAR, TAR, and progress notes did not include full sets of vital signs every 4 hours per provider orders between 1/17/24 and 1/23/24. R7's HR was documented zero times on 1/17/24 and BP was recorded once. HR and BP were noted twice on 1/18/24 and 1/19/24, three times on 1/20/24 and 1/21/24, twice on 1/22/24, and three times on 1/23/24. In an interview on 1/24/24 at 11:46 a.m., the DON stated R7's care plan was not updated and was not resident-centered regarding COVID-19. The DON stated R8's vital signs monitoring was missing some vital sign components and did not follow facility policy or professional standards of practice. R8's MDS dated 1/7/24, noted R8 was admitted on 12/31/23 with diagnoses including schizophrenia, diabetes, morbid obesity, obstructive sleep apnea (intermittent interruptions in breathing while asleep), acute and chronic respiratory failure, and utilized continuous supplementary oxygen. R8 had a BIMS score of	F 684		

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F 684	Continued From page 24 13 indicating no cognitive impairment, required substantial assistance with mobility in bed, and was dependent on staff for transfers, bathing, and dressing. The initial physician visit note dated 1/17/24, notes R8 was admitted to the facility after a hospitalization in December of 2023 for influenza and pneumonia with respiratory failure requiring intubation (severe respiratory failure requiring mechanical assistance to breathe). A progress note dated 1/21/24 at 1:11 p.m., indicated R8 tested positive for COVID-19. R8's care plan without date of last review due to R8's recent admission included interventions most recently added on 1/14/24 but did not contain any focus or interventions related to COVID-19. R8's provider orders dated 1/21/24, indicated COVID-19 positive monitoring including check temperature, O2 sat, and RR every four hours ending 1/31/24 and directed to update provider every shift with any changes in vital signs. A provider order dated 1/22/24, noted a prescription for Molnupiravir (an antiviral medication used to treat mild-to-moderate COVID-19 for adults at high risk of disease progression) for five days to treat COVID-19. R8's vital sign record, MAR, TAR, and progress notes did not include full sets of vital signs every four hours per provider orders. On 1/21/24, R8's RR, HR, BP, and temperature were each recorded once and O2 sat was recorded three times. On 1/22/24, RR, HR, BP, and temperature	F 684		

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F 684	Continued From page 25 were each recorded twice, though O2 was recorded six times. On 1/23/24, RR, HR, BP, and temperature were each recorded once and O2 sat was recorded four times. In an interview on 1/24/24 at 11:46 a.m., the DON stated R8's care plan was not updated or resident-centered regarding COVID-19. The DON stated R8's vital signs monitoring did not follow facility policy or professional standards of practice. The facility's Care Planning policy dated 11/2023, included: "(2) A comprehensive care plan must be: A) Developed within 7 days after completion of the comprehensive assessment. B) Prepared by an interdisciplinary team, that includes but is not limited to: i)The attending physician; ii) A registered nurse with responsibility for the resident; iii) A nurse aide with responsibility for the resident; iv) A member of food and nutrition services staff; v) 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; vi) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. C) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive, quarterly, and significant change review assessments. (3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must:	F 684		

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F 684	Continued From page 26 A) Meet professional standards of quality. B) Be provided by qualified persons in accordance with each resident's written plan of care. C) Be culturally-competent and trauma-informed." The IJ that began on 1/3/24, was removed on 1/25/24, when the facility updated order sets for residents with COVID-19 to include monitoring of full sets of vital signs every shift and implemented these orders for all residents affected, revised the process for activating these orders, integrated vital sign monitoring mandatory task into TARs, updated care plans for all residents with COVID-19 to include appropriate interventions, created skilled nursing progress note templates for residents with COIVD-19 and other respiratory illnesses to be completed every shift that include vital signs and assessment of clinical condition, provided nursing staff with education about the new processes and reinforced education about notification of providers for changes in condition, and implemented audits of charting and monitoring, but the noncompliance remained at the lower scope and severity level of E because the facility needs to update policies update policies and procedures for comprehensive assessment, monitoring, developing and revising person-centered care plans, and implementing interventions in accordance with professional standards of practice for all respiratory illnesses.	F 684		

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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: On 1/22/24 through 1/26/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were reviewed H51828956C (MN100059) and H51829024C	2 000		

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

Electronically Signed | 02/12/24

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2 000	Continued From page 1 (MN100109). NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		