Electronically delivered
October 8, 2020

Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

RE: CCN: 245218
Cycle Start Date: September 24, 2020

Dear Administrator:

On September 24, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend

to the CMS Region V Office that one or more of the following remedies be imposed:

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

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 December 24, 2020 (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 March 24, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245218	A. BUILDING _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	**500 WEST GRANT STREET LAKE CITY, MN 55041**

(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 9/24/20 an abbreviated survey was completed at your facility to conduct complaint investigations. Your facility was found NOT to be in compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5218029. Deficiencies issued at F609 and F610. The following complaints were found unsubstantiated: H5218028C and H5218027C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property,	F 609		11/2/20

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

Electronically Signed | 10/16/2020

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 609	Continued From page 1 are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to immediately report an allegation of staff-to-resident verbal abuse to the state agency (SA) within two hours for 1 of 3 residents (R2) reviewed for abuse. Findings include: R2's initial vulnerable adult report submitted to the SA on 1/16/20 included "2 staff members reported to DON [director of nursing] that a travel nursing assistant [alleged perpetrator] was found to be yelling at resident [R2]. DON [director of nursing] spoke with [R2] and he did not appreciate her tone. It appears she wanted to assist him with cares and [R2] told her no. [Alleged perpetrator] began to yell at [R2]	F 609	Submission of this Allegation of Compliance is not a legal admission that a deficiency exists or that this Statement of deficiencies was correctly cited and is also not to be construed as an admission against the Facility, Administrator, of any Employees, Agents or other individuals who draft or may be discussed in the Allegation of Compliance. In addition, preparation and submission of the Allegation of Compliance does not constitute an admission or an agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the Statement by the survey agency. Accordingly, the Facility has prepared and submitted this	

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F 609	Continued From page 2 because she became offended when [R2] talked back to her. DON [director of nursing] will be interviewing staff and residents to obtain a clearer picture of this staff member and whether or not the issue is widespread. DON [director of nursing] has reached out to [pool agency] and they are addressing with the staff member as I am typing this report. DON [director of nursing] will submit 5 day investigation when complete. Actions will be taken to keep [R2] and other residents safe during investigation." Review of the initial report made to the SA revealed the incident occurred on 1/16/20, at 5:00 a.m. and the initial report was made to the SA on 1/16/20 at 9:55 a.m. During an interview on 9/24/20, at 4:30 p.m., nursing assistant (NA)-A stated she immediately reported the incident to the nurse. During an interview on 9/24/20, at 4:44 p.m., licensed practical nurse (LPN)-A stated she did not recall when or how she notified the DON and indicated she may have emailed or told him in person. During an interview on 9/24/20, at 5:54 p.m., the administrator stated any alleged abused needed to be submitted to state agency (SA) within 2 hours of being reported. The administrator stated staff are to notify the DON via phone if offsite or after hours and the DON was responsible for filing the report to the SA. The administrator verified the initial report was filed over 4 hours and close to 5 hours after the incident occurred. The administrator stated he would expect staff to report any allegation of abuse timely and would expect the report to be filed to the state agency within 2 hours of the occurrence.	F 609	Allegation of Compliance solely because of the requirements under State and Federal law that mandate submission of an Allegation of Compliance within ten days of receipt of the Statement of Deficiencies as a condition of participation in Title 18 and Title 19 programs. The submission of this Allegation of Compliance within this timeframe should in no way be considered or construed as an agreement with allegations of noncompliance or admissions by the facility. This plan of correction is not to be construed as an admission by the facility or any of its agents that the survey agents findings in this report are true or correct. The plan of correction is written for the purpose of compliance with the rules of participation for the Medicaid and Medicare programs. On 9/24/2020, MDH completed a complaint survey and noted the facility failed to immediately report an allegation of staff to resident verbal abuse to the state agency within two hours for 1 of 3 residents (R2) reviewed for abuse. Facility is correcting this tag through the following interventions: Administrator will review policies and procedures regarding reporting of all alleged abuse, neglect, or mistreatment. Allegations of abuse, neglect, or mistreatment will be reported to the state agency within two hours. Administrator or designee will re-educate staff on the two hour timeframe for reporting allegations of abuse, neglect, or mistreatment. Staff will be re-educated on	

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F 609	Continued From page 3 The Vulnerable Adult - Abuse Prohibition Plan dated 4/19 included, "Mandated reporters in skilled nursing facilities ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported, and a report made immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials in accordance with State Law through established procedures."	F 609	the company policy and procedures surrounding such allegations. Education will be completed by 10/30/2020. Audits will be conducted weekly for two months and randomly thereafter for three months to ensure allegations of abuse, neglect, or mistreatment are reported within two hours. Results of the audits will be reviewed at the Quality Assurance Committee for follow up and recommendations to ensure ongoing compliance and those solutions are sustained. Administrator will be responsible to ensure compliance.	
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:	F 610		11/2/20

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F 610	Continued From page 4 Based on interview and document review, the facility failed to thoroughly investigate allegations of abuse for 1 of 3 residents (R2) reviewed. Findings include: R2's initial vulnerable adult report submitted to the SA on 1/16/20, at 9:55 a.m. included "2 staff members reported to DON [director of nursing] that a travel nursing assistant [alleged perpetrator] was found to be yelling at resident [R2]. DON [director of nursing] spoke with [R2] and he did not appreciate her tone. It appears she wanted to assist him with cares and [R2] told her no. [Alleged perpetrator] began to yell at [R2] because she became offended when [R2] talked back to her. DON [director of nursing] will be interviewing staff and residents to obtain a clearer picture of this staff member and whether or not the issue is widespread. DON [director of nursing] has reached out to [pool agency] and they are addressing with the staff member as I am typing this report. DON [director of nursing] will submit 5 day investigation when complete. Actions will be taken to keep [R2] and other residents safe during investigation." Review of the initial report made to the SA revealed the incident occurred on 1/16/20, at 5:00 a.m. and the initial report was made to the SA on 1/16/20 at 9:44 a.m. The MDH five day investigation report dated 1/20/20 at 1:37 p.m., indicated the resident (R2) and staff involved were interviewed. However, there was no documentation of these interviews by the facility. Review of this report revealed there was no additional documentation of residents or staff interviews completed related to the incident.	F 610	Submission of this Allegation of Compliance is not a legal admission that a deficiency exists or that this Statement of deficiencies was correctly cited and is also not to be construed as an admission against the Facility, Administrator, of any Employees, Agents or other individuals who draft or may be discussed in the Allegation of Compliance. In addition, preparation and submission of the Allegation of Compliance does not constitute an admission or an agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the Statement by the survey agency. Accordingly, the Facility has prepared and submitted this Allegation of Compliance solely because of the requirements under State and Federal law that mandate submission of an Allegation of Compliance within ten days of receipt of the Statement of Deficiencies as a condition of participation in Title 18 and Title 19 programs. The submission of this Allegation of Compliance within this timeframe should in no way be considered or construed as an agreement with allegations of noncompliance or admissions by the facility. This plan of correction is not to be construed as an admission by the facility or any of its agents that the survey agents findings in this report are true or correct. The plan of correction is written for the purpose of compliance with the rules of participation for the Medicaid and Medicare programs. On 9/24/2020, MDH completed a	

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F 610	Continued From page 5 During an interview on 9/24/20 at 2:12 p.m., the DON stated he summarized his interviews in the 5 day report and did not keep his documentation of the interviews. DON stated he would normally document other residents or staff interviewed in the 5 day report. DON stated he believed he interviewed others but since it was not indicated in the report and there was no documentation of the interviews, he does not have anything to back it up. DON verified his investigation was not reproducible. During an interview on 9/24/20, at 5:54 p.m., the administrator stated he spoke to the DON and verified the documentation of investigation and interviews cannot be reproduced. The administrator stated, "It sure would be nice to have right now" and would expect all documentation of the investigation and interviews to be kept. The Vulnerable Adult - Abuse Prohibition Plan dated 4/19 included, The Building Charge, Nurse Manager or Director of Nursing, or Administrator will immediately institute an internal investigation of the reported allegation or incident. The investigation may include but not limited to; a. Interviews of staff and written statements from staff involved in the incident b. Resident interviews c. Witness interviews and written statements of the incident ..."	F 610	complaint survey and noted the facility failed to thoroughly investigate allegations of abuse for 1 of 3 residents (R2) reviewed. Facility is correcting this tag through the following interventions: Administrator will review policies and procedures around conducting a complete and thorough investigation. Reports submitted to the state agency will contain supporting documentation, such as staff and resident interviews. Administrator or designee will re-educate leadership on the importance of completing and documenting all parts of the investigation, including staff and resident interviews. Education will be completed by 10/30/2020. Audits will be conducted weekly for two months and randomly thereafter for three months to ensure reports to the state agency contain the proper interviews and documentation. Results of the audits will be reviewed at the Quality Assurance Committee for follow up and recommendations to ensure ongoing compliance and those solutions are sustained. Administrator will be responsible to ensure compliance.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 8, 2020

Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

Re: State Nursing Home Licensing Orders
Event ID: LHXY11

Dear Administrator:

The above facility was surveyed on September 24, 2020 through September 24, 2020 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:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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	00770	A. BUILDING: _____ B. WING _____	C 09/24/2020

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2 000	Initial Comments	2 000		

*****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 9/24/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to NOT be IN compliance with the MN State Licensure.

The following complaint was found to be SUBSTANTIATED: H5218029 and licensing

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	500 WEST GRANT STREET LAKE CITY, MN 55041

(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
2 000	Continued From page 1 orders were issued. The following complaints were found to be UNSUBSTANTIATED: H5218028C and H5218027C. NO licensing orders were issued. 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		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to immediately report an allegation of staff-to-resident verbal abuse to the state agency (SA) within two hours for 1 of 3 residents (R2) reviewed for abuse. Findings include: R2's initial vulnerable adult report submitted to the SA on 1/16/20 included "2 staff members	21995	Submission of this Allegation of Compliance is not a legal admission that a deficiency exists or that this Statement of deficiencies was correctly cited and is also not to be construed as an admission against the Facility, Administrator, of any Employees, Agents or other individuals who draft or may be discussed in the Allegation of Compliance. In addition, preparation and submission of the	11/2/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00770	A. BUILDING: _____ B. WING _____	C 09/24/2020

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21995	Continued From page 2	21995		

reported to DON [director of nursing] that a travel nursing assistant [alleged perpetrator] was found to be yelling at resident [R2]. DON [director of nursing] spoke with [R2] and he did not appreciate her tone. It appears she wanted to assist him with cares and [R2] told her no. [Alleged perpetrator] began to yell at [R2] because she became offended when [R2] talked back to her. DON [director of nursing] will be interviewing staff and residents to obtain a clearer picture of this staff member and whether or not the issue is widespread. DON [director of nursing] has reached out to [pool agency] and they are addressing with the staff member as I am typing this report. DON [director of nursing] will submit 5 day investigation when complete. Actions will be taken to keep [R2] and other residents safe during investigation." Review of the initial report made to the SA revealed the incident occurred on 1/16/20, at 5:00 a.m. and the initial report was made to the SA on 1/16/20 at 9:55 a.m.

During an interview on 9/24/20, at 4:30 p.m., nursing assistant (NA)-A stated she immediately reported the incident to the nurse.

During an interview on 9/24/20, at 4:44 p.m., licensed practical nurse (LPN)-A stated she did not recall when or how she notified the DON and indicated she may have emailed or told him in person.

During an interview on 9/24/20, at 5:54 p.m., the administrator stated any alleged abused needed to be submitted to state agency (SA) within 2 hours of being reported. The administrator stated staff are to notify the DON via phone if offsite or after hours and the DON was responsible for filing the report to the SA. The administrator verified the initial report was filed over 4 hours

Allegation of Compliance does not constitute an admission or an agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the Statement by the survey agency. Accordingly, the Facility has prepared and submitted this Allegation of Compliance solely because of the requirements under State and Federal law that mandate submission of an Allegation of Compliance within ten days of receipt of the Statement of Deficiencies as a condition of participation in Title 18 and Title 19 programs. The submission of this Allegation of Compliance within this timeframe should in no way be considered or construed as an agreement with allegations of noncompliance or admissions by the facility. This plan of correction is not to be construed as an admission by the facility or any of its agents that the survey agents findings in this report are true or correct. The plan of correction is written for the purpose of compliance with the rules of participation for the Medicaid and Medicare programs.

On 9/24/2020, MDH completed a complaint survey and noted the facility failed to immediately report an allegation of staff to resident verbal abuse to the state agency within two hours for 1 of 3 residents (R2) reviewed for abuse. Facility is correcting this tag through the following interventions:
Administrator will review policies and procedures regarding reporting of all alleged abuse, neglect, or mistreatment. Allegations of abuse, neglect, or

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21995	Continued From page 3 and close to 5 hours after the incident occurred. The administrator stated he would expect staff to report any allegation of abuse timely and would expect the report to be filed to the state agency within 2 hours of the occurrence. The Vulnerable Adult - Abuse Prohibition Plan dated 4/19 included, "Mandated reporters in skilled nursing facilities ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported, and a report made immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials in accordance with State Law through established procedures." SUGGESTED METHOD OF CORRECTION: The administrator could review policies and procedures regarding reporting of all alleged abuse/neglect/mistreatment. The administrator and or designee, could re-educate all staff on the policies and procedures. The administrator could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21995	mistreatment will be reported to the state agency within two hours. Administrator or designee will re-educate staff on the two hour timeframe for reporting allegations of abuse, neglect, or mistreatment. Staff will be re-educated on the company policy and procedures surrounding such allegations. Education will be completed by 10/30/2020. Audits will be conducted weekly for two months and randomly thereafter for three months to ensure allegations of abuse, neglect, or mistreatment are reported within two hours. Results of the audits will be reviewed at the Quality Assurance Committee for follow up and recommendations to ensure ongoing compliance and those solutions are sustained. Administrator will be responsible to ensure compliance.	