



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 6, 2022

Administrator
Mahnomen Health Center
414 West Jefferson Avenue
Mahnomen, MN 56557

RE: CCN: 245238
Cycle Start Date: August 26, 2022

Dear Administrator:

On August 26, 2022, 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" and/or an E tag), i.e., the plan of correction should be directed to:

LeAnn Huseeth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota. 56537
Email: leann.huseeth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 November 26, 2022 (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 February 26, 2023 (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/ltr_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.

Mahnomen Health Center

September 6, 2022

Page 4

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

Kamala Fiske-Downing

Minnesota Department of Health

Licensing and Certification Program

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

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

PRINTED: 10/03/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/26/2022
NAME OF PROVIDER OR SUPPLIER MAHNOMEN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 WEST JEFFERSON AVENUE MAHNOMEN, MN 56557		
(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 8/25/22, to 8/26/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H52384297C (MN86185), with deficiencies cited at (F609 and F580). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 580 SS=D	Notify of Changes (Injury/Degrade/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 580			9/19/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/13/2022

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 580	Continued From page 1 clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the family member was	F 580	08/22/2022 Education was provided to the nurse who		

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F 580	Continued From page 2 notified of a change of condition in a timely manner for 1 of 1 resident (R1) who sustained fractured ribs resulting from an unwitnessed fall. Finding include: R1's quarterly Minimum Data Set (MDS) dated 8/17/22, indicated R1 had diagnoses which included hypertension, anxiety, localized edema and had severe cognitive impairment. The MDS indicated R1 required extensive assistance of one staff for bed mobility, transfers, dressing, personal hygiene, toileting, bathing and required assistance of staff for walking. The MDS identified R1 utilized a walker, a wheelchair and was not steady with movement and required staff assistance to stabilize herself. R1's MDS indicated R1 had a fall on her prior assessment with injury. Review of R1's care plan revised on 8/25/22, indicated R1 was at risk for falls related to edema, anemia, moderate vision impairment and severe hearing impairment. The care plan listed various interventions which included: staff were to provide toileting assistance and were not leave R1 in bathroom alone. Review of R1's Event Report dated 8/21/22, at 12:46 a.m. identified R1 had an unwitnessed fall at 8:30 p.m. on 8/20/22, and was found on the floor sitting next to the toilet. Nursing assistant (NA)-A and NA-B assisted R1 up off the floor utilizing a gait belt, positioned her back onto the toilet and proceeded to walk R1 back to her recliner with her walker. The report indicated registered nurse (RN)-A was notified of R1's fall at 9:00 p.m. and assessed R1 with no visible signs of injury. At 10:00 p.m. R1 was brought out	F 580	did not report fall to the family. All falls need to be reported immediately to the family. Resident's family was notified 08/22/2022 of fall after resident was found to have an injury. It was not known until that time the family was not notified at the time of the fall. 08/23/2022 To prevent this from happening to other residents, all staff were educated on notifying families of all falls at the time of the fall. This was done by phone and zoom meetings. Education was completed by 09/08/2022. Each fall will be audited as soon as possible after the fall to ensure family was notified and OHFC report has been made. This will be monitored and followed through QAPI. 08/20/2022 An intervention was put into place immediately after the fall for the resident. She is not to be left alone on the toilet and staff need to be within arm's reach. Staff were notified via communication book and care plan was updated. 08/24/2022 All residents who are assisted with toileting are not to be left alone on the toilet. This will assist with falls prevention. Staff were educated by 09/08/2022 Staff meeting held to educate staff the proper protocol for falls and reporting of falls. Staff meeting minutes were sent out to all staff through When I Work chat for those not in attendance. Zoom meetings, phone calls and one on ones, were held for those who were not able to attend in person. All staff educated at the time of		

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F 580	Continued From page 3 to the commons area to sit per her request and at 12:00 a.m. R1 requested to go back to her room. While RN-A was attempting to ambulate R1 with her walker, she had complaints of lower back pain on her left side. RN-A assessed R1, gave her Tylenol, applied bio-freeze to the area and called the provider in the emergency room (ER). The ER provider instructed staff to continue to monitor and offer as needed Tylenol for pain control. The report indicated R1's FM-A was notified of the unwitnessed fall on 8/22/22 at 11:40 a.m. Review of R1 progress notes from 8/20/22, to 8/23/22, revealed the following: - on 8/21/22, at 12:58 p.m. R1 had complaints of leg pain, Tylenol was administered and was effective. - on 8/22/22, at 11:41 a.m. R1's family member (FM)-A was updated on R1's fall and was scheduled for an appointment at the clinic to follow up on her pain to her lower back from the fall. - on 8/23/22, at 10:49 a.m. follow up clinic appointment, x-rays identified R1 had rib fractures on her left side. The provider instructed staff to continue with Tylenol as needed for pain. The progress note indicated staff would be using the standing mechanical lift for transfers from that point forward as a gait belt may be too painful to her ribs. The note identified staff were updated on the use of the standing mechanical lift. Review of R1's medical record, revealed staff had not notified R1's FM-A for 39 hours after R1 had an unwitnessed fall which resulted in lower back pain and fractured ribs. During an interview on 8/25/22, at 2:39 p.m. RN-A	F 580	their next scheduled shift. All staff were reminded, if they are gone for a long period of time from work, they need to read the communication book and review care plans prior to stepping on the floor to ensure they are up to date on all care plans. They were also educated to ask other co-workers if there are any changes before performing ADLs, transfers, toileting on residents to ensure they are up to date on the care plans. OHFC reporting requirements were reviewed as well. All falls are now to be reported to OHFC. This will give us time to determine if the care plan was followed, but still report within the required time frame. All fall care plans will be reviewed by 09/09/2022 to ensure all proper interventions are in place. New walkie talkies were ordered for staff to be able to communicate without leaving residents. Walkies were received and put into use by 09/07/2022. Reporting of falls will be audited with each fall to ensure proper reporting and the care plan was followed. These audits will be monitored and followed through QAPI.		

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F 580	Continued From page 4 confirmed the above findings. RN-A stated R1 had an unwitnessed fall on 8/20/22, around 8:00 or 8:20 p.m. and NA-A reported to him R1 had fallen off the toilet when NA-A left her unattended. RN-A indicated he notified the director of nursing (DON) of R1's fall on 8/21/22, around 12:56 a.m. and indicated staff had not followed R1's care plan by leaving her unattended in the bathroom. RN-A verified R1 was having some lower back pain resulting from the fall and had not notified R1's family. During an interview on 8/26/22, at 9:19 a.m. the DON confirmed the above findings and indicated she was notified on Saturday 8/20/22, around midnight, of R1's unwitnessed fall and R1's complaints of lower back pain. The DON verified RN-A had not notified R1's family when she fell, and the family had not been notified until 8/22/22. The DON indicated her expectation of staff were to update and notify family in a timely manner and follow facility policies. During an interview on 8/26/22, at 9:59 a.m. FM-A indicated she was R1's primary emergency contact. FM-A confirmed the facility had not contacted her about R1's 8/20/22, fall until 8/22/22, at around 11:00 a.m. On 8/26/22, a facility policy was requested for notification of family with change of condition, and one was not provided.	F 580			
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:	F 609			9/19/22

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F 609	Continued From page 5 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to timely report an allegation of potential neglect of care with major injury for 1 of 1 resident (R1) immediately but no later than 2 hours to the administrator and State Agency (SA). Findings include: R1's quarterly Minimum Data Set (MDS) dated 8/17/22, indicated R1 had diagnoses which included hypertension, anxiety, localized edema and had severe cognitive impairment. The MDS	F 609	08/22/2022 Education was provided to the nurse who did not report fall to the family. All falls need to be reported immediately to the family. Resident's family was notified 08/22/2022 of fall after resident was found to have an injury. It was not known until that time the family was not notified at the time of the fall. 08/23/2022 To prevent this from happening to other residents, all staff were educated on		

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F 609	Continued From page 6 indicated R1 required extensive assistance of one staff for bed mobility, transfers, dressing, personal hygiene, toileting, bathing and required assistance of staff for walking in room. The MDS identified R1 utilized a walker, a wheelchair and was not steady with movement and required staff assistance to stabilize herself. R1's MDS indicated R1 had a fall on her prior assessment with injury. Review of R1's care plan revised on 8/25/22, indicated R1 was at risk for falls related to edema, anemia, moderate vision impairment and severe hearing impairment. The care plan listed various interventions which included: staff were to provide toileting assistance and were not leave R1 in bathroom alone. Review of R1's Event Report dated 8/21/22, at 12:46 a.m., identified R1 had an unwitnessed fall at 8:30 p.m. on 8/20/22., and was found on the floor sitting next to the toilet. Nursing assistant (NA)-A and NA-B assisted R1 up off the floor utilizing a gait belt and positioned her back onto the toilet and proceeded to walk R1 back to her recliner with her walker. The report indicated registered nurse (RN)-A was notified of R1's fall at 9:00 p.m., and assessed R1 with no visible signs of injury. At 10:00 p.m. R1 was brought out to the commons area to sit per her request and at 12:00 a.m. R1 wanted to go back to her room. While RN-A was attempting to ambulating R1 with her walker, she had complaints of lower back pain on her left side. RN-A assessed R1, gave her Tylenol and applied bio-freeze to the area and called the provider in the emergency room (ER). The ER provider indicated to continue to monitor and offer as needed Tylenol for pain control.	F 609	notifying families of all falls at the time of the fall. This was done by phone and zoom meetings. Education was completed by 09/08/2022. Each fall will be audited as soon as possible after the fall to ensure family was notified and OHFC report has been made. This will be monitored and followed through QAPI. 08/20/2022 An intervention was put into place immediately after the fall for the resident. She is not to be left alone on the toilet and staff need to be within arm's reach. Staff were notified via communication book and care plan was updated. 08/24/2022 All residents who are assisted with toileting are not to be left alone on the toilet. This will assist with falls prevention. Staff were educated by 09/08/2022 Staff meeting held to educate staff the proper protocol for falls and reporting of falls. Staff meeting minutes were sent out to all staff through When I Work chat for those not in attendance. Zoom meetings, phone calls and one on ones, were held for those who were not able to attend in person. All staff educated at the time of their next scheduled shift. All staff were reminded, if they are gone for a long period of time from work, they need to read the communication book and review care plans prior to stepping on the floor to ensure they are up to date on all care plans. They were also educated to ask other co-workers if there are any changes before performing ADLs, transfers, toileting on residents to ensure they are		

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F 609	Continued From page 7 Review of R1 progress notes from 8/20/22, to 8/23/22, revealed the following: - on 8/21/22, at 12:58 p.m. R1 had complaints of leg pain, Tylenol was administered and was effective. - on 8/22/22, at 11:41 a.m. R1's family member (FM)-A was updated on R1's fall and was scheduled for an appointment at the clinic to follow up on her pain to her lower back from the fall. - on 8/23/22, at 10:49 a.m. follow up clinic appointment, x-rays identified R1 had rib fractures on her left side. The provider instructed staff to continue with Tylenol as needed for pain. The progress note indicated staff would be using the standing mechanical lift for transfers from that point forward as a gait belt may be too painful to her ribs. The note identified staff were updated on the use of the standing mechanical lift. Review of the Incident Report # 348952, submitted to the SA on 8/23/22, at 9:15 a.m. listed an allegation of neglect with a fall in the bathroom for R1 and listed the incident had occurred on 8/21/22, with no time noted. The incident report indicated R1 had fractured ribs and interviews were started with staff as well as education provided to staff. The report identified the allegation of neglect had been reported to the SA on 8/23/21, at 9:15 a.m. The allegation of neglect was reported to the SA two and a half days later after the incident had been reported by staff on 8/20/22, to RN-A. During an interview on 8/25/22, at 2:39 p.m. RN-A confirmed the above findings and indicated R1 required staff assistance with transfers and ambulation while utilizing a gait belt and walker. RN-A indicated R1 was at risk for falls and was	F 609	up to date on the care plans. OHFC reporting requirements were reviewed as well. All falls are now to be reported to OHFC. This will give us time to determine if the care plan was followed, but still report within the required time frame. All fall care plans will be reviewed by 09/09/2022 to ensure all proper interventions are in place. New walkie talkies were ordered for staff to be able to communicate without leaving residents. Walkies were received and put into use by 09/07/2022. Reporting of falls will be audited with each fall to ensure proper reporting and the care plan was followed. These audits will be monitored and followed through QAPI.		

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

PRINTED: 10/03/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/26/2022
NAME OF PROVIDER OR SUPPLIER MAHNOMEN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 WEST JEFFERSON AVENUE MAHNOMEN, MN 56557		
(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 609	Continued From page 8 able to use her call light for assistance however R1 was not to be left alone in the bathroom due to having a tendency to self-transfer at times. RN-A indicated R1 had fallen on 8/20/22, around 8:00 or 8:20 p.m. and NA-A reported to him R1 had fallen off the toilet. RN-A indicated NA-A had to use the bathroom and had reported off to NA-B to check on R1 while she was using the bathroom. RN-A indicated when NA-A returned to R1's room, R1 was sitting on the floor next to the toilet. RN-A indicated NA-A called for assistance, NA-C assisted her to transfer R1 back up onto the toilet using a gait belt and walked R1 back to her recliner with the walker. RN-A indicated he notified the director of nursing of R1's fall on 8/21/22, around 12:56 a.m. During a telephone interview on 8/26/22, at 8:27 a.m. NA-A confirmed the above findings and indicated R1 required staff assistance with transfers and ambulation using a gait belt and walker. NA-A stated she had brought R1 back to her room after supper on 8/20/22, at around 7:00 p.m. to use the bathroom and was assisting her to get ready for bed when she suddenly had to use the bathroom herself. NA-A indicated she left R1 on the toilet and reported off to NA-B to check on R1 while she used the bathroom. NA-A stated when she was done using the bathroom, she returned to R1's room, found her sitting on the floor next to the toilet and was leaning to her left. NA-A indicated she asked NA-C for assistance. NA-A stated she and NA-C boosted R1 back up onto the toilet from the floor using a gait belt and assisted R1 to walk back to her recliner using her walker. NA-A indicated R1 walked with a limp after her fall on 8/20/22, and had reported the incident to the nurse right away. NA-A indicated she was not aware R1 was not supposed to be	F 609			

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F 609	Continued From page 9 left unattended in the bathroom and believed NA-B would check on her. During an interview on 8/26/22, at 9:19 a.m. the DON confirmed the above findings. The DON indicated R1 was a fall risk and should not have been left unattended on the toilet. The DON stated her expectations of staff were to follow R1's care plan as written. The DON indicated she was notified on Saturday 8/20/22, around midnight, although she did not read the message until the morning of 8/21/22. The DON verified any allegations of abuse or neglect would need to be reported to the SA immediately within two hours. The DON indicated she would expect staff to follow the facility's policy and procedures for timely reporting to the SA. Review of the facility policy titled, Reporting of Maltreatment of Vulnerable Adult dated 7/21, directed under the heading "Reporting/Response: Reporting of Abuse and/or Neglect Required. Follow the OHFC (Office of Health Facility Complaints) Investigation Process Policy ... All employees of the facility were mandated reporters and must report all incidents of actual or suspected maltreatment." The policy defined neglect as the failure or omission of a care giver to supply the vulnerable adult with care or services, including but not limited to food, clothing, shelter, health care or supervision. The failure of the facility, its employees or service providers to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish, or emotional distress. Further, the policy defined serious bodily harm as "an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the	F 609			

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F 609	Continued From page 10 function of bodily member, organ or mental faculty; or requiring medical intervention such as surgery, hospitalization or physical rehabilitation. In addition, the policy defined immediately as "No later than two hours after forming the suspicion, if events that caused the suspicion involved abuse or result in serious bodily injury, or not later than 24 hours if events that caused the suspicion did not involve abuse and did not result in serious bodily injury. The facility policy OHFC Investigation Process Policy dated 7/21, indicated the purpose of the policy was to document resident incidents, to conduct an investigation of each incident, and to identify root causes for future prevention. The scope of the policy identified all Mahnomen Health Center staff and directed under the policy procedure the incident was to be "Reported to OHFC (Immediately or within 2 hours of initial report if abuse or bodily harm or no later than 24 hours if no bodily harm)."	F 609			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 6, 2022

Administrator
Mahnomen Health Center
414 West Jefferson Avenue
Mahnomen, MN 56557

Re: Event ID: GRJ911

Dear Administrator:

The above facility survey was completed on August 26, 2022 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,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00353	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/26/2022
NAME OF PROVIDER OR SUPPLIER MAHNOMEN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 WEST JEFFERSON AVENUE MAHNOMEN, MN 56557		
(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	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 8/25/22, to 8/26/22, 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 complaint was found to be SUBSTANTIATED:	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

09/13/22

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00353	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/26/2022
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2 000	Continued From page 1 H52384297C (MN86185), however 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			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
October 6, 2022

Administrator
Mahnomen Health Center
414 West Jefferson Avenue
Mahnomen, MN 56557

RE: CCN: 245238
Cycle Start Date: August 26, 2022

Dear Administrator:

On October 4, 2022, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 6, 2022

Administrator
Mahnomen Health Center
414 West Jefferson Avenue
Mahnomen, MN 56557

RE: CCN: 245238
Cycle Start Date: August 26, 2022

Dear Administrator:

On August 26, 2022, 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" and/or an E tag), i.e., the plan of correction should be directed to:

LeAnn Huseeth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota. 56537
Email: leann.huseeth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 November 26, 2022 (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 February 26, 2023 (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/ltr_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.

Mahnomen Health Center

September 6, 2022

Page 4

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

Kamala Fiske-Downing

Minnesota Department of Health

Licensing and Certification Program

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 6, 2022

Administrator
Mahnomen Health Center
414 West Jefferson Avenue
Mahnomen, MN 56557

Re: Event ID: GRJ911

Dear Administrator:

The above facility survey was completed on August 26, 2022 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,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

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F 000	INITIAL COMMENTS On 8/25/22, to 8/26/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H52384297C (MN86185), with deficiencies cited at (F609 and F580). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 580 SS=D	Notify of Changes (Injury/Degrade/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 580			9/19/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/13/2022

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.

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

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F 580	Continued From page 1 clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the family member was	F 580	08/22/2022 Education was provided to the nurse who		

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

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F 580	Continued From page 2 notified of a change of condition in a timely manner for 1 of 1 resident (R1) who sustained fractured ribs resulting from an unwitnessed fall. Finding include: R1's quarterly Minimum Data Set (MDS) dated 8/17/22, indicated R1 had diagnoses which included hypertension, anxiety, localized edema and had severe cognitive impairment. The MDS indicated R1 required extensive assistance of one staff for bed mobility, transfers, dressing, personal hygiene, toileting, bathing and required assistance of staff for walking. The MDS identified R1 utilized a walker, a wheelchair and was not steady with movement and required staff assistance to stabilize herself. R1's MDS indicated R1 had a fall on her prior assessment with injury. Review of R1's care plan revised on 8/25/22, indicated R1 was at risk for falls related to edema, anemia, moderate vision impairment and severe hearing impairment. The care plan listed various interventions which included: staff were to provide toileting assistance and were not leave R1 in bathroom alone. Review of R1's Event Report dated 8/21/22, at 12:46 a.m. identified R1 had an unwitnessed fall at 8:30 p.m. on 8/20/22, and was found on the floor sitting next to the toilet. Nursing assistant (NA)-A and NA-B assisted R1 up off the floor utilizing a gait belt, positioned her back onto the toilet and proceeded to walk R1 back to her recliner with her walker. The report indicated registered nurse (RN)-A was notified of R1's fall at 9:00 p.m. and assessed R1 with no visible signs of injury. At 10:00 p.m. R1 was brought out	F 580	did not report fall to the family. All falls need to be reported immediately to the family. Resident's family was notified 08/22/2022 of fall after resident was found to have an injury. It was not known until that time the family was not notified at the time of the fall. 08/23/2022 To prevent this from happening to other residents, all staff were educated on notifying families of all falls at the time of the fall. This was done by phone and zoom meetings. Education was completed by 09/08/2022. Each fall will be audited as soon as possible after the fall to ensure family was notified and OHFC report has been made. This will be monitored and followed through QAPI. 08/20/2022 An intervention was put into place immediately after the fall for the resident. She is not to be left alone on the toilet and staff need to be within arm's reach. Staff were notified via communication book and care plan was updated. 08/24/2022 All residents who are assisted with toileting are not to be left alone on the toilet. This will assist with falls prevention. Staff were educated by 09/08/2022 Staff meeting held to educate staff the proper protocol for falls and reporting of falls. Staff meeting minutes were sent out to all staff through When I Work chat for those not in attendance. Zoom meetings, phone calls and one on ones, were held for those who were not able to attend in person. All staff educated at the time of		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 580	Continued From page 3 to the commons area to sit per her request and at 12:00 a.m. R1 requested to go back to her room. While RN-A was attempting to ambulate R1 with her walker, she had complaints of lower back pain on her left side. RN-A assessed R1, gave her Tylenol, applied bio-freeze to the area and called the provider in the emergency room (ER). The ER provider instructed staff to continue to monitor and offer as needed Tylenol for pain control. The report indicated R1's FM-A was notified of the unwitnessed fall on 8/22/22 at 11:40 a.m. Review of R1 progress notes from 8/20/22, to 8/23/22, revealed the following: - on 8/21/22, at 12:58 p.m. R1 had complaints of leg pain, Tylenol was administered and was effective. - on 8/22/22, at 11:41 a.m. R1's family member (FM)-A was updated on R1's fall and was scheduled for an appointment at the clinic to follow up on her pain to her lower back from the fall. - on 8/23/22, at 10:49 a.m. follow up clinic appointment, x-rays identified R1 had rib fractures on her left side. The provider instructed staff to continue with Tylenol as needed for pain. The progress note indicated staff would be using the standing mechanical lift for transfers from that point forward as a gait belt may be too painful to her ribs. The note identified staff were updated on the use of the standing mechanical lift. Review of R1's medical record, revealed staff had not notified R1's FM-A for 39 hours after R1 had an unwitnessed fall which resulted in lower back pain and fractured ribs. During an interview on 8/25/22, at 2:39 p.m. RN-A	F 580	their next scheduled shift. All staff were reminded, if they are gone for a long period of time from work, they need to read the communication book and review care plans prior to stepping on the floor to ensure they are up to date on all care plans. They were also educated to ask other co-workers if there are any changes before performing ADLs, transfers, toileting on residents to ensure they are up to date on the care plans. OHFC reporting requirements were reviewed as well. All falls are now to be reported to OHFC. This will give us time to determine if the care plan was followed, but still report within the required time frame. All fall care plans will be reviewed by 09/09/2022 to ensure all proper interventions are in place. New walkie talkies were ordered for staff to be able to communicate without leaving residents. Walkies were received and put into use by 09/07/2022. Reporting of falls will be audited with each fall to ensure proper reporting and the care plan was followed. These audits will be monitored and followed through QAPI.		

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F 580	Continued From page 4 confirmed the above findings. RN-A stated R1 had an unwitnessed fall on 8/20/22, around 8:00 or 8:20 p.m. and NA-A reported to him R1 had fallen off the toilet when NA-A left her unattended. RN-A indicated he notified the director of nursing (DON) of R1's fall on 8/21/22, around 12:56 a.m. and indicated staff had not followed R1's care plan by leaving her unattended in the bathroom. RN-A verified R1 was having some lower back pain resulting from the fall and had not notified R1's family. During an interview on 8/26/22, at 9:19 a.m. the DON confirmed the above findings and indicated she was notified on Saturday 8/20/22, around midnight, of R1's unwitnessed fall and R1's complaints of lower back pain. The DON verified RN-A had not notified R1's family when she fell, and the family had not been notified until 8/22/22. The DON indicated her expectation of staff were to update and notify family in a timely manner and follow facility policies. During an interview on 8/26/22, at 9:59 a.m. FM-A indicated she was R1's primary emergency contact. FM-A confirmed the facility had not contacted her about R1's 8/20/22, fall until 8/22/22, at around 11:00 a.m. On 8/26/22, a facility policy was requested for notification of family with change of condition, and one was not provided.	F 580			
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:	F 609			9/19/22

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F 609	Continued From page 5 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to timely report an allegation of potential neglect of care with major injury for 1 of 1 resident (R1) immediately but no later than 2 hours to the administrator and State Agency (SA). Findings include: R1's quarterly Minimum Data Set (MDS) dated 8/17/22, indicated R1 had diagnoses which included hypertension, anxiety, localized edema and had severe cognitive impairment. The MDS	F 609	08/22/2022 Education was provided to the nurse who did not report fall to the family. All falls need to be reported immediately to the family. Resident's family was notified 08/22/2022 of fall after resident was found to have an injury. It was not known until that time the family was not notified at the time of the fall. 08/23/2022 To prevent this from happening to other residents, all staff were educated on		

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F 609	Continued From page 6 indicated R1 required extensive assistance of one staff for bed mobility, transfers, dressing, personal hygiene, toileting, bathing and required assistance of staff for walking in room. The MDS identified R1 utilized a walker, a wheelchair and was not steady with movement and required staff assistance to stabilize herself. R1's MDS indicated R1 had a fall on her prior assessment with injury. Review of R1's care plan revised on 8/25/22, indicated R1 was at risk for falls related to edema, anemia, moderate vision impairment and severe hearing impairment. The care plan listed various interventions which included: staff were to provide toileting assistance and were not leave R1 in bathroom alone. Review of R1's Event Report dated 8/21/22, at 12:46 a.m., identified R1 had an unwitnessed fall at 8:30 p.m. on 8/20/22., and was found on the floor sitting next to the toilet. Nursing assistant (NA)-A and NA-B assisted R1 up off the floor utilizing a gait belt and positioned her back onto the toilet and proceeded to walk R1 back to her recliner with her walker. The report indicated registered nurse (RN)-A was notified of R1's fall at 9:00 p.m., and assessed R1 with no visible signs of injury. At 10:00 p.m. R1 was brought out to the commons area to sit per her request and at 12:00 a.m. R1 wanted to go back to her room. While RN-A was attempting to ambulating R1 with her walker, she had complaints of lower back pain on her left side. RN-A assessed R1, gave her Tylenol and applied bio-freeze to the area and called the provider in the emergency room (ER). The ER provider indicated to continue to monitor and offer as needed Tylenol for pain control.	F 609	notifying families of all falls at the time of the fall. This was done by phone and zoom meetings. Education was completed by 09/08/2022. Each fall will be audited as soon as possible after the fall to ensure family was notified and OHFC report has been made. This will be monitored and followed through QAPI. 08/20/2022 An intervention was put into place immediately after the fall for the resident. She is not to be left alone on the toilet and staff need to be within arm's reach. Staff were notified via communication book and care plan was updated. 08/24/2022 All residents who are assisted with toileting are not to be left alone on the toilet. This will assist with falls prevention. Staff were educated by 09/08/2022 Staff meeting held to educate staff the proper protocol for falls and reporting of falls. Staff meeting minutes were sent out to all staff through When I Work chat for those not in attendance. Zoom meetings, phone calls and one on ones, were held for those who were not able to attend in person. All staff educated at the time of their next scheduled shift. All staff were reminded, if they are gone for a long period of time from work, they need to read the communication book and review care plans prior to stepping on the floor to ensure they are up to date on all care plans. They were also educated to ask other co-workers if there are any changes before performing ADLs, transfers, toileting on residents to ensure they are		

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F 609	Continued From page 7 Review of R1 progress notes from 8/20/22, to 8/23/22, revealed the following: - on 8/21/22, at 12:58 p.m. R1 had complaints of leg pain, Tylenol was administered and was effective. - on 8/22/22, at 11:41 a.m. R1's family member (FM)-A was updated on R1's fall and was scheduled for an appointment at the clinic to follow up on her pain to her lower back from the fall. - on 8/23/22, at 10:49 a.m. follow up clinic appointment, x-rays identified R1 had rib fractures on her left side. The provider instructed staff to continue with Tylenol as needed for pain. The progress note indicated staff would be using the standing mechanical lift for transfers from that point forward as a gait belt may be too painful to her ribs. The note identified staff were updated on the use of the standing mechanical lift. Review of the Incident Report # 348952, submitted to the SA on 8/23/22, at 9:15 a.m. listed an allegation of neglect with a fall in the bathroom for R1 and listed the incident had occurred on 8/21/22, with no time noted. The incident report indicated R1 had fractured ribs and interviews were started with staff as well as education provided to staff. The report identified the allegation of neglect had been reported to the SA on 8/23/21, at 9:15 a.m. The allegation of neglect was reported to the SA two and a half days later after the incident had been reported by staff on 8/20/22, to RN-A. During an interview on 8/25/22, at 2:39 p.m. RN-A confirmed the above findings and indicated R1 required staff assistance with transfers and ambulation while utilizing a gait belt and walker. RN-A indicated R1 was at risk for falls and was	F 609	up to date on the care plans. OHFC reporting requirements were reviewed as well. All falls are now to be reported to OHFC. This will give us time to determine if the care plan was followed, but still report within the required time frame. All fall care plans will be reviewed by 09/09/2022 to ensure all proper interventions are in place. New walkie talkies were ordered for staff to be able to communicate without leaving residents. Walkies were received and put into use by 09/07/2022. Reporting of falls will be audited with each fall to ensure proper reporting and the care plan was followed. These audits will be monitored and followed through QAPI.		

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F 609	Continued From page 8 able to use her call light for assistance however R1 was not to be left alone in the bathroom due to having a tendency to self-transfer at times. RN-A indicated R1 had fallen on 8/20/22, around 8:00 or 8:20 p.m. and NA-A reported to him R1 had fallen off the toilet. RN-A indicated NA-A had to use the bathroom and had reported off to NA-B to check on R1 while she was using the bathroom. RN-A indicated when NA-A returned to R1's room, R1 was sitting on the floor next to the toilet. RN-A indicated NA-A called for assistance, NA-C assisted her to transfer R1 back up onto the toilet using a gait belt and walked R1 back to her recliner with the walker. RN-A indicated he notified the director of nursing of R1's fall on 8/21/22, around 12:56 a.m. During a telephone interview on 8/26/22, at 8:27 a.m. NA-A confirmed the above findings and indicated R1 required staff assistance with transfers and ambulation using a gait belt and walker. NA-A stated she had brought R1 back to her room after supper on 8/20/22, at around 7:00 p.m. to use the bathroom and was assisting her to get ready for bed when she suddenly had to use the bathroom herself. NA-A indicated she left R1 on the toilet and reported off to NA-B to check on R1 while she used the bathroom. NA-A stated when she was done using the bathroom, she returned to R1's room, found her sitting on the floor next to the toilet and was leaning to her left. NA-A indicated she asked NA-C for assistance. NA-A stated she and NA-C boosted R1 back up onto the toilet from the floor using a gait belt and assisted R1 to walk back to her recliner using her walker. NA-A indicated R1 walked with a limp after her fall on 8/20/22, and had reported the incident to the nurse right away. NA-A indicated she was not aware R1 was not supposed to be	F 609			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 609	Continued From page 9 left unattended in the bathroom and believed NA-B would check on her. During an interview on 8/26/22, at 9:19 a.m. the DON confirmed the above findings. The DON indicated R1 was a fall risk and should not have been left unattended on the toilet. The DON stated her expectations of staff were to follow R1's care plan as written. The DON indicated she was notified on Saturday 8/20/22, around midnight, although she did not read the message until the morning of 8/21/22. The DON verified any allegations of abuse or neglect would need to be reported to the SA immediately within two hours. The DON indicated she would expect staff to follow the facility's policy and procedures for timely reporting to the SA. Review of the facility policy titled, Reporting of Maltreatment of Vulnerable Adult dated 7/21, directed under the heading "Reporting/Response: Reporting of Abuse and/or Neglect Required. Follow the OHFC (Office of Health Facility Complaints) Investigation Process Policy ... All employees of the facility were mandated reporters and must report all incidents of actual or suspected maltreatment." The policy defined neglect as the failure or omission of a care giver to supply the vulnerable adult with care or services, including but not limited to food, clothing, shelter, health care or supervision. The failure of the facility, its employees or service providers to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish, or emotional distress. Further, the policy defined serious bodily harm as "an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the	F 609			

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F 609	Continued From page 10 function of bodily member, organ or mental faculty; or requiring medical intervention such as surgery, hospitalization or physical rehabilitation. In addition, the policy defined immediately as "No later than two hours after forming the suspicion, if events that caused the suspicion involved abuse or result in serious bodily injury, or not later than 24 hours if events that caused the suspicion did not involve abuse and did not result in serious bodily injury. The facility policy OHFC Investigation Process Policy dated 7/21, indicated the purpose of the policy was to document resident incidents, to conduct an investigation of each incident, and to identify root causes for future prevention. The scope of the policy identified all Mahnomen Health Center staff and directed under the policy procedure the incident was to be "Reported to OHFC (Immediately or within 2 hours of initial report if abuse or bodily harm or no later than 24 hours if no bodily harm)."	F 609			

Minnesota Department of Health

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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 8/25/22, to 8/26/22, 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 complaint was found to be SUBSTANTIATED:	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

09/13/22

Minnesota Department of Health

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2 000	Continued From page 1 H52384297C (MN86185), however 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			