Electronically delivered

April 5, 2021

Administrator
Regina Senior Living
1175 Nininger Road
Hastings, MN 55033

RE: CCN: 245254
Cycle Start Date: March 17, 2021

Dear Administrator:

On April 4, 2021, we informed you that we may impose enforcement remedies.

On March 22, 2021, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

REMEDIES

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

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 17, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 17, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 17, 2021.

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

payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 17, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Regina Senior Living will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 17, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 17, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 03/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	**1175 NININGER ROAD HASTINGS, MN 55033**

(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 3/22/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5254036C (MN70162) and H5254037C (MN71039) with deficiency at F740. 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 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental	F 740		4/23/21

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

Electronically Signed | 04/14/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 740	Continued From page 1 and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to identify individualized mental health interventions and provide behavioral health monitoring for 1 of 1 residents (R1) who had increased thoughts of being better off dead or hurting themselves. Findings include: R1's annual Minimum Data Set (MDS) dated 12/1/20, indicated R1 was cognitively intact based on a Brief Inventory of Mental Status (BIMS) score of 13. R1's Patient Health Questionnaire (PHQ-9) mood interview score was 6, which indicated mild depression. R1 denied thoughts of being better off dead or hurting self. R1's diagnoses included aphasia, epilepsy, traumatic brain injury, anxiety disorder and depression. R1 received daily antidepressant medication. R1's quarterly MDS dated 2/23/21, indicated R1's PHQ-9 score was 12 which indicated moderate depression. R1 had thoughts of being better off dead or hurting self seven to eleven days in the 14 day assessment period. R1 continued to receive daily antidepressant medication. R1's social service progress note dated 2/22/21, at 10:08 a.m. indicated R1's PHQ-9 score was 12 which indicated moderate depressive symptoms. R1 had adjusted well to placement, and that mood and behaviors were "variable". The progress note lacked further assessment of the increased PHQ-9 score and lacked documentation of new interventions.	F 740	Disclaimer: Preparation, submission and implementation of the Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This plan of correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facilities allegation of compliance. R1's PHQ-9 was done by staff assessment on 4/7/2021. R1 will have all subsequent PHQ-9 assessments done by staff assessment quarterly, for any significant change and as needed assessments due to behavioral expressions indicating increased depression. R1's care plan has been updated with interventions to address to his psycho-social well-being. Retraining of staff that are responsible to administer the PHQ-9 on the required follow up with nursing and providers, depending on the resident's responses during the PHQ-9 assessment. Nursing and Providers will be notified regarding any resident that answers "yes" to the question on the PHQ-9 stating that they have "thoughts to harm self". Social Service Director will review all	

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F 740	Continued From page 2 R1's care plan last edited 2/24/21, indicated a problem area for psychosocial well-being. R1 was at risk for psychosocial well-being r/t (related to) medically imposed restrictions r/t COVID-19 precautions. R1's goal was to not show a decline in psychosocial well-being or experience adverse effects through next care review. The care plan directed staff to observe for psychosocial and mental status changes and document and report as indicated. There were no additional individualized interventions documented r/t increase in PHQ-9 score. A nurse practitioner (NP) note dated 3/1/21, documented that R1 had episodes of crying and irritability, and described his mood as somewhat erratic but overall improved. The provider declined gradual dose reduction "for mood medications especially with pandemic". The NP note did not contain any evidence to indicate the provider was updated in regards to the increased PHQ-9 score, nor were there any additional orders to implement any individualized interventions. Progress note dated 3/17/2021, at 4:00 p.m. registered nurse (RN)-A documented R1 cried through cares while he was assisted to bed. Progress noted dated 3/17/2021, at 5:01 p.m. RN-A entered R1's room and found R1 lying on his back in bed with his baseball cap over his face. When he did not respond to RN-A's greeting she removed the cap and found him with the call light cord wrapped around his neck and crossed over his throat and used both of his hands to pull the cord. The cord was removed, the resident's neck was assessed, and RN-A called R1's provider.	F 740	PHQ-9 assessments that are done by ancillary staff for 4 weeks. Then, a random sample of PHQ-9's completed will be reviewed by the Social Service Director for another 4 weeks. Policy SS017 Interventions for those at Risk of Suicide and Policy NS010 Comprehensive Assessment and Care Planning were reviewed and remain current. Person Responsible: Social Service Director or Designee All staff that perform PHQ-9 assessments will be re-educated on the proper administration of the PHQ-9 including follow up with nursing and provider requirements by 4-9-21. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. All education and corrections to be completed by 4/23/2021	

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F 740	Continued From page 3	F 740		

A progress note dated 3/17/21, at 7:04 p.m. indicated the NP was updated on the situation. The guardian was also notified of the situation and declined to sent R1 to the emergency room. The facility put immediate safety interventions in place for R1.

During an interview on 3/22/21, at 9:35 a.m. guardian A stated R1 had became more aggressive and defiant, and expressed "heightened emotions of late".

During an interview on 3/22/21, at 11:23 a.m. director of social services (SS)-A stated she had not worked directly with R1, and the social services designee had followed R1. SS-A stated there was a history of demeanor changes after certain after phone calls, indoor and window visit with his mom, and the situation had been discussed in care conferences. Questions arose whether those visits were beneficial to R1 or caused harm. No further information was provided by SS-A.

During an interview on 3/22/21, at 1:52 p.m. the social services designee (SS)-B stated she worked with R1 since admission, and that in the past if R1 had a really bad day he sometimes made gestures to imitate a gun and point it at his head, but she had not seen him do this recently. No further information was provided by SS-B or further information in regards to the response to R1 who made an imitation of a gun to his head.

During an interview on 3/22/21, at 4:25 p.m. the director of nursing (DON) stated they [the facility] were unaware of any history of suicidal ideation.

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F 740	Continued From page 4	F 740		

During an interview on 3/22/21, at 4:26 p.m. SS-A stated that if a significant change in PHQ-9 score was to occur, the resident's provider would be updated, psychiatric services would be offered, and family would be updated. No further information was provided to indicate the provider was made aware of the increased PHQ-9 score, psychiatric services were offered or family/guardian were updated. Additionally there was no further information provided by the facility to show behavioral health interventions were developed after R1 made comments that in a 14 day assessment period he felt better off dead or wanted to hurt himself.

The facility policy entitled, Interventions for Those at Risk of Suicide dated 2014, contained the following procedure:
-Residents deemed at risk for suicide will be assessed by a medical professional ASAP [as soon as possible].
-Residents will be screened for mood indicators, including SI [suicidal ideation - thoughts of being dead or of killing oneself], through assessments including social history and PHQ-9 according to the RAI [resident assessment instrument] assessment schedule. If the answer to I. in the PHQ-9 regarding thoughts of being better off dead or wanting to hurt themselves, Attachment A, PHQ-9 addendum will be completed.
-If a resident's statements or actions reflect SI at any time, immediate actions are taken to maintain safety. The situation is reported to the physician or established psychologist to evaluate the threat. Per policy, "these would be noted in oral or written statements or gestures by the person."

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 5, 2021

Administrator
Regina Senior Living
1175 Nininger Road
Hastings, MN 55033

Re: Event ID: M4V811

Dear Administrator:

The above facility survey was completed on March 22, 2021 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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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 3/22/21, 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: H5254036C (MN70162) and	2 000		

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2 000	Continued From page 1 H5254037C (MN71039). 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		