



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

August 31, 2021

Administrator
Augustana HCC Of Apple Valley
14650 Garrett Avenue
Apple Valley, MN 55124

RE: CCN: 245264
Cycle Start Date: August 13, 2021

Dear Administrator:

On August 13, 2021, survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On August 13, 2021, the situation of immediate jeopardy to potential health and safety cited at F684 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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 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:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 15, 2021.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 15, 2021, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 15, 2021, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 13, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

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

notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Augustana HCC Of Apple Valley is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 13, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

**Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720**

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 13, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

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

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

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

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

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

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

Augustana HCC Of Apple Valley

August 31, 2021

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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

Program Assurance Unit

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: 08/31/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245264		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/13/2021	
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HCC OF APPLE VALLEY				STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124			
(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 8/11/21, through 8/13/21, 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 complaints were found to be SUBSTANTIATED: H5264135C (MN75431), with a deficiency cited at (F684). The following complaints were found to be UNSUBSTANTIATED, however related deficiencies were cited. H5264136C (MN75386), with a deficiency cited at (F609). The survey resulted in an Immediate Jeopardy (IJ) at F684 when the facility failed to identify and report a significant change of condition to the physician (MD), emergency medical services (EMS), and the resident's representative in a timely manner for 1 of 3 residents (R1) reviewed for a change in condition. The administrator and the director of nursing (DON) were notified of the IJ on 8/12/21, at 2:25 p.m. The IJ began on 7/29/21, and was removed on 8/13/21. The above findings constituted substandard quality of care, and an extended survey was conducted on 8/13/21. 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			F 000			

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

TITLE

(X6) DATE

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

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F 000	Continued From page 1 form. Your electronic submission of the POC will be used as verification of compliance.	F 000			
F 609 SS=D	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. Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, 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.	F 609			

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F 609	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the State Agency (SA) was notified immediately (within 2 hours) of an allegation of physical abuse involving 2 of 3 residents (R2, R3) reviewed for allegations of abuse. Findings include: R2's Face Sheet printed 8/13/21, indicated R2's diagnoses included alcohol abuse, history of falling, and chronic kidney disease. R2's admission Minimum Data Set (MDS) dated 6/3/21, indicated R2 was cognitively intact and required limited assistance with most actives of daily living (ADLs). R2's care plan dated 6/1/21, indicated R2 was at risk for abuse/neglect due to vulnerable status living in an nursing home and would remain safe and free from abuse. R3's Face Sheet printed 8/13/21, indicated R3's diagnosis included major depressive disorder, personality disorder, and dementia with behavioral disturbance. R3's quarterly MDS dated 5/12/21, indicated R3 had a moderate cognitive impairment and required extensive assistance with most ADLs. R3's care plan dated 7/31/21, indicted R3 had mood concerns and history of hitting staff, throwing objects at staff, and verbally abusing staff. The care plan also indicated R3 threatened to throw things at other residents when they went	F 609			

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F 609	Continued From page 3 past his room. R3 was to have 1 on 1 staff supervision when he was out of bed and present at facility. On 7/30/21, at 4:16 p.m. a progress note indicated R2 stated another resident [R3] had been yelling and swearing at her while she was near the front desk trying to pass by him. R2 stated that [R3] kicked her in the left leg, and that it hurt for a while. The incident was immediately reported to the floor nurse. On 7/31/21, at 11:41 a.m. a progress note indicated follow up from note on 7/30/21. No injury observed to [R2]. No redness, no bruising, no skin tears, no warmth, or tenderness to the touch present to R2's left shin. [R2] reported she feels safe in the facility. Director of nursing (DON) and administrator updated. On 7/31/21, at 11:42 a.m. a progress note indicated 1 on 1 supervision was implemented for R3 when he was out of bed. R3's care plan was updated. On 8/11/21, at 9:47 a.m. R2 was interviewed and stated there was an ongoing issue when she encountered R3. R2 stated R3 had "wheeled up to me and gave me a kick in the shin." R2 stated she reported this to therapeutic recreation aide (TR)-A. On 8/11/21, at 10:30 a.m. TR-A was interviewed and stated he spoke with R2 on 7/30/21, and she "looked a little distraught." R2 stated R3 had sworn at her and kicked her as well. TR-A stated he had reported this to registered nurse (RN)-B, who "didn't say much."	F 609			

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F 609	Continued From page 4 On 8/11/21, at 10:55 a.m. RN-A was interviewed and stated he discovered TR-A's progress note regarding R2's abuse allegation on 7/31/21. RN-A placed a call to the DON who indicated the allegation had not been addressed. RN-A initialed an investigation and reported to alleged abuse to the SA. RN-A stated the allegation should have should have been reported immediately. On 8/11/21, at 1:43 p.m. the DON was interviewed and verified all facility staff were mandated reporters, and allegations should initially be reported to the direct supervisor immediately. The DON verified allegation was not reported immediately. On 8/16/21, at 12:56 p.m. RN-B was interviewed and verified she was informed of the allegation by TR-A and did not report it. RN-B stated she meant to report it but "things got a little busy at work and I forgot." RN-B verified allegations of abuse and neglect should be reported immediately. The facility policy Vulnerable adult-MN dated 10/31/19, directed all staff, family members, volunteers and residents must report suspected/alleged abuse, neglect, exploitation of residents, mistreatment of residents, and/or misappropriation of resident property immediately. Each employee is responsible to report suspected/alleged violations immediately, but no later than 2 hours after the allegation is made.	F 609			
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684			

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F 684	Continued From page 5 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify and report a significant change of condition to the resident's medical provider, and the resident's representative in a timely manner for 1 of 3 residents (R1) reviewed for a change in condition. This resulted in an immediate jeopardy (IJ). The IJ began on 7/29/21, at 7:45 a.m. when nursing assistant (NA)-A found R1 unresponsive. NA-A reported this to registered nurse (RN)-A, who stated it could be a stroke. RN-A did not conduct a thorough assessment of R1, and did not contact R1's nurse practitioner (NP)-A to report R1 was unresponsive until 10:14 a.m., and at that time did not give full report that R1 was not responding. In addition, RN-A failed to notify R1's family on the change in condition. R1 was transported to the hospital at 3:20 p.m. at the request of R1's family. R1 died on 8/2/21. The administrator and the director of nursing (DON) were notified of the IJ on 8/12/21, at 2:25 p.m.. The IJ was removed on 8/13/21, at 2:59 p.m. but non-compliance remained at the lower scope and severity of a D, potential for more than minimal harm. Findings include:	F 684			

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F 684	Continued From page 6 R1's Face Sheet printed 8/16/21, indicated R1's diagnoses included fracture of fifth metatarsal bone of the right foot, Parkinson's disease, and congestive heart failure (CHF). R1's admission Minimum Data Set (MDS) dated 5/26/21, indicated R1 was cognitively intact, utilized a wheelchair, and required extensive assistance with most activities of daily living (ADLs). R1's care plan dated 5/21/21, indicated R1 made herself understood and understood others. R1's care plan further directed staff to monitor for changes in condition, and notify provider and resident representative as indicated. On 7/29/21, at 3:25 p.m. a progress note indicated R1 had been lethargic and unresponsive throughout the shift. RN-A had checked on R1 several times throughout the shift. R1's vitals were taken and were normal. NP-A had been notified and requested a blood sugar check. If the check was normal, call back later in the shift if R1 continued to be lethargic. R1's blood sugar was 120. R1's family member (FM)-A arrived sometime after noon and were concerned about R1. RN-A called NP-A again, noting R1 had not improved, and family was concerned. While awaiting return call from NP-A, FM-A requested R1 be sent in to the emergency department (ED). 911 was called to transfer R1, who left the facility at 3:20 p.m.. R1's medical record lacked any indication of a change in condition prior to the progress note entered at 3:25 p.m. on 7/29/21. On 7/29/21, at 11:36 p.m. a progress note	F 684			

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F 684	Continued From page 7 indicated FM-A was called and R1's condition was discussed. FM-A stated R1 had a major stroke, had a poor prognosis, and FM-A had been told R1's condition was "terminal." R1's United Hospital Emergency Room Notes dated 7/29/21, indicated R1 was unresponsive to physical or verbal stimulation. R1 had difficulty clearing secretions in the back of her oropharynx (throat) and had acute right-sided hemiparesis (weakness on one side of the body). R1 was found to have "a very large left-sided ACA (anterior cerebral artery) and MCA (middle cerebral artery) stroke, not recoverable." Genevieve Triage Call Log (log indicating when NP-A had been contacted) indicated two calls were received from RN-A to NP-A regarding R1. The first call was on 7/29/21, at 10:14 a.m. and the second call was on 7/29/21, at 2:13 p.m.. On 8/11/21, at 11:10 a.m. FM-A was interviewed and stated he went to visit R1 at approximately 2:00 p.m. on 7/29/21. FM-A stated R1 was lying in bed, with her lunch tray unopened on the bedside table which was "unusual" as R1 was always up. FM-A stated he attempted to waken R1 and could not. FM-A stated he went to the nurse's station and spoke with RN-A, who told him he had previously checked R1's vital signs, and R1 had been tired all day. FM-A returned to R1's room and attempted to awaken her again and could not. FM-A stated he returned to RN-A asked if NP-A had been called. FM-A stated he attempted to find another staff member to assess R1 and could not. FM-A stated he again went to RN-A and asked for a nurse manager. FM-A stated RN-A told him the RN managers were in care conferences. FM-A went to the first floor and with	F 684			

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F 684	Continued From page 8 the assistance of social service worker (SS)-A found RN-C in the hallway. RN-C and the DON went to speak with RN-A, and directed RN-A to conduct additional assessments. FM-A stated RN-A began taking R1's vital signs and assessing R1, and shortly after emergency medical services (EMS) arrived. FM-A stated when EMS arrived, they asked RN-A how R1 had been that morning and RN-A had stated "just like this." EMS stated to FM-A that R1 appeared to have had a stroke sometime in the night. When at the hospital, the ED staff told FM-A that R1 had a major stroke, most likely a terminal event. R1 passed away in the hospital on 8/2/21. On 8/11/21, at 2:02 p.m. RN-A was interviewed and stated on 7/29/21, NA-A approached him around 8:00 a.m. and stated R1 was still sleeping, and was not reactive to being changed. RN-A stated he worked with R1 the day before and she was up for breakfast. RN-A stated he had assessed R1 and she "appeared to be just sleeping" but was not responsive to verbal or physical stimulation. RN-A stated at approximately 9:00 a.m. he checked on R1 again, and she was still unresponsive. RN-A stated he took R1's vital signs, and attempted a pain stimulus check with no response. RN-A stated he called NP-A at approximately 9:30 a.m. and left a message with the triage line. RN-A stated about 30 minutes later the triage line called with instructions to take R1's blood sugar, attempt to get R1 up into her wheelchair, continue to monitor her, and call back if she did not become responsive. RN-A stated he felt that transferring R1 was unsafe and R1 "would have just slid out of the chair." RN-A stated he was unable to awaken R2 for lunch, which was abnormal as R1 would usually go to the dining room for meals.	F 684			

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F 684	Continued From page 9 RN-A stated FM-A arrived, and was concerned. RN-A explained he had called NP-A, went to check on her R1 again and she was still in the same position that she was in throughout the day. RN-A again called NP-A at approximately 1:30 p.m. and left a message that R1's condition had not changed. RN-A stated FM-A called the DON who came and instructed RN-A to conduct neuro-checks (used to assess an individual's neurological functions and level of consciousness to determine whether the individual is functioning properly and reacting appropriately to the tests) on R1. RN-A stated this was "the first time anyone mentioned a neuro-check." RN-A stated he completed the assessments and noted R1 was unresponsive to pain and unable to participate in neuro-checks. RN-A stated before receiving a return call from NP-A, FM-A requested R1 be sent to the hospital. RN-A stated he did not feel he could call 911 without doctors' or NP orders unless a resident was in dire, urgent need. RN-A stated he wanted assistance from a nurse manager but could not find them as they were in care conferences and "in the past I have been told not to bother them during care conferences." RN-A further stated, "Looking back, I should have called 911." On 8/11/21, at 2:33 p.m. NA-B was interviewed and stated she had worked with R1 on the evening of 7/28/21. NA-B stated she had provided R1 with an evening snack, assisted her in night cares, and got R1 into bed around 9:00 p.m. NA-B stated she checked on R1 around 9:30 p.m. before the end of her shift, and R1 indicated to NA-B that everything was fine. On 8/11/21, at 2:39 p.m. NA-A was interviewed and stated on 7/29/21, at about 7:30 a.m. she	F 684			

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F 684	Continued From page 10 observed R1 to have her eyes closed and was snoring. NA-A stated she attempted to awaken R1, but she was not responding. NA-A stated she attempted to reposition R1 onto her side to change her incontinent brief, but R1 was unable to participate in repositioning or gripping the side rail on her bed. NA-A stated she reported this to RN-A, who came to check R1's vital signs. When NA-A asked RN-A what was wrong with R1, RN-A stated he did not know and thought it could be a stroke, or she could be super sleepy. NA-A stated shortly after this she brought R1's breakfast tray in, and attempted to awaken R1 by shaking her and calling her name, but R1 was not responsive. NA-A stated she had not seen R1 like this in previous days. NA-A stated she continued to check on R1 and attempt to awaken her throughout the shift and "she was still like that." NA-A stated she asked RN-A how R1 was doing several times and RN-A told her he did not know yet. NA-A stated R1's condition had not improved throughout her shift. On 8/12/21, 10:19 a.m. RN-C was interviewed and stated she was in care conferences from about 1:00 p.m. until 2:30 p.m. on 7/29/21. RN-C stated SS-A approached her and stated there was a problem on the unit with R1. RN-C stated she went to R1's room and observed R1 lying in bed with her head slightly elevated, and eyes closed. RN-C stated RN-A was in the room attempting to take R1's vital signs. FM-A stated this was not R1's normal behavior, and RN-C immediately noticed a change in condition for R1 and stated, "I thought it was a stroke." RN-C stated RN-A told her he had called 911 per FM-A's request. RN-C was present when EMS arrived, and she heard EMS staff say R1 appeared to have had a stroke. RN-C stated EMS	F 684			

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F 684	Continued From page 11 asked RN-A how long R1 had been in that condition, and RN-A stated all shift. RN-C stated would have expected RN-A to inform her of a change in condition, and the family and medical provider also be informed right way. RN-C further stated she would expect staff to call 911 if concerns with a resident did not resolve and there was "always someone who is available" for nursing staff to consult with about resident concerns. On 8/12/21, at 10:36 a.m. the DON was interviewed. The DON stated on 7/29/21, at around 2:45 p.m. she was approached by SS-A and FM-A who informed her R1 was not waking up. The DON stated she went to speak with RN-A, who verified R1 was unresponsive, and also informed her he had contacted NP-A twice. The DON stated she instructed RN-A to conduct a neuro-assessment, check lung sounds, and vital signs. The DON stated she informed FM-A they could request for R1 to be sent into the hospital if they wanted treatment, which FM-A was in agreement with. The DON stated RN-A should have conducted a neurological assessment on R1 sooner. The DON stated while it was the common practice to get orders to call 911, staff could call 911 without orders, especially if family is requesting. The DON stated nurses have education on what to do if a resident has a change in condition. On 8/12/21, at 12:47 p.m. NP-A was interviewed and stated she received a message from R1 that staff was unable to awaken R1, and R1 was sleepy but comfortable. NP-A reviewed R1's medications and directed RN-A to take R1's blood sugar and vital signs. NP-A stated she did not recommend RN-A do neuro-checks on R1 as she	F 684			

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F 684	Continued From page 12 assumed RN-A had conducted neuro-checks as part of his initial assessment, and would have reported any abnormalities. NP-A stated she was not aware R1 was unresponsive, only that she was sleepy. NP-A stated it would have been helpful to have a more thorough assessment from RN-A to determine R1's needs. NP-A verified signs and symptoms of stroke include a change in mental status, weakness, impairment in walking or talking, total paralysis or weakness on one side, drooling, and drooping in the face. The facility policy Transfer of Resident to Hospital reviewed 12/9/19, directed: For life threatening emergencies: Check the resident's Code Status form/POLST/MOST, call 911, if indicated. Then notify physician and primary contact of the emergency and transfer. The facility policy Notification of Physician and Resident Representative revised 2/25/20, directed primary physicians, residents, and the resident representative, consistent with their authority, will be updated with all resident condition changes as soon as possible. The names of those contacted will be documented in the progress notes. The policy further directed If a physician is unavailable or does not respond in a timely manner, nurse will contact 911 if indicated. In the event of an emergency licensed staff have the discretion to transfer via 911 emergency services to the hospital. If the facility staff feel additional consultation is required concerning a resident's condition, a call would be placed to the director of nursing (or designee) and to the medical director. Additional notifications to home office staff would be made as indicated.	F 684			

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F 684	Continued From page 13 The facility policy Change in Condition revised 2/25/20, directed the nurse will notify the resident's attending physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition; Unless otherwise instructed by the resident, a nurse will notify the resident's representative when there is a significant change in the resident's physical, mental, or psychosocial status; Facility staff will also notify the RN in charge or the RN on call as indicated when changes in resident condition occur. The IJ was removed on 8/13/21, at 2:59 p.m. after it was verified through interview and document review the facility implemented a systemic plan of reeducation and policy change regarding change in condition.	F 684			

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F 000	INITIAL COMMENTS On 8/11/21, through 8/13/21, 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 complaints were found to be SUBSTANTIATED: H5264135C (MN75431), with a deficiency cited at (F684). The following complaints were found to be UNSUBSTANTIATED, however related deficiencies were cited. H5264136C (MN75386), with a deficiency cited at (F609). The survey resulted in an Immediate Jeopardy (IJ) at F684 when the facility failed to identify and report a significant change of condition to the physician (MD), emergency medical services (EMS), and the resident's representative in a timely manner for 1 of 3 residents (R1) reviewed for a change in condition. The administrator and the director of nursing (DON) were notified of the IJ on 8/12/21, at 2:25 p.m. The IJ began on 7/29/21, and was removed on 8/13/21. The above findings constituted substandard quality of care, and an extended survey was conducted on 8/13/21. 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	F 000			

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

TITLE

(X6) DATE

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

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F 000	Continued From page 1 form. Your electronic submission of the POC will be used as verification of compliance.	F 000			
F 609 SS=D	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. Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, 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.	F 609			

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F 609	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the State Agency (SA) was notified immediately (within 2 hours) of an allegation of physical abuse involving 2 of 3 residents (R2, R3) reviewed for allegations of abuse. Findings include: R2's Face Sheet printed 8/13/21, indicated R2's diagnoses included alcohol abuse, history of falling, and chronic kidney disease. R2's admission Minimum Data Set (MDS) dated 6/3/21, indicated R2 was cognitively intact and required limited assistance with most actives of daily living (ADLs). R2's care plan dated 6/1/21, indicated R2 was at risk for abuse/neglect due to vulnerable status living in an nursing home and would remain safe and free from abuse. R3's Face Sheet printed 8/13/21, indicated R3's diagnosis included major depressive disorder, personality disorder, and dementia with behavioral disturbance. R3's quarterly MDS dated 5/12/21, indicated R3 had a moderate cognitive impairment and required extensive assistance with most ADLs. R3's care plan dated 7/31/21, indicted R3 had mood concerns and history of hitting staff, throwing objects at staff, and verbally abusing staff. The care plan also indicated R3 threatened to throw things at other residents when they went	F 609			

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F 609	Continued From page 3 past his room. R3 was to have 1 on 1 staff supervision when he was out of bed and present at facility. On 7/30/21, at 4:16 p.m. a progress note indicated R2 stated another resident [R3] had been yelling and swearing at her while she was near the front desk trying to pass by him. R2 stated that [R3] kicked her in the left leg, and that it hurt for a while. The incident was immediately reported to the floor nurse. On 7/31/21, at 11:41 a.m. a progress note indicated follow up from note on 7/30/21. No injury observed to [R2]. No redness, no bruising, no skin tears, no warmth, or tenderness to the touch present to R2's left shin. [R2] reported she feels safe in the facility. Director of nursing (DON) and administrator updated. On 7/31/21, at 11:42 a.m. a progress note indicated 1 on 1 supervision was implemented for R3 when he was out of bed. R3's care plan was updated. On 8/11/21, at 9:47 a.m. R2 was interviewed and stated there was an ongoing issue when she encountered R3. R2 stated R3 had "wheeled up to me and gave me a kick in the shin." R2 stated she reported this to therapeutic recreation aide (TR)-A. On 8/11/21, at 10:30 a.m. TR-A was interviewed and stated he spoke with R2 on 7/30/21, and she "looked a little distraught." R2 stated R3 had sworn at her and kicked her as well. TR-A stated he had reported this to registered nurse (RN)-B, who "didn't say much."	F 609			

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F 609	Continued From page 4 On 8/11/21, at 10:55 a.m. RN-A was interviewed and stated he discovered TR-A's progress note regarding R2's abuse allegation on 7/31/21. RN-A placed a call to the DON who indicated the allegation had not been addressed. RN-A initialed an investigation and reported to alleged abuse to the SA. RN-A stated the allegation should have should have been reported immediately. On 8/11/21, at 1:43 p.m. the DON was interviewed and verified all facility staff were mandated reporters, and allegations should initially be reported to the direct supervisor immediately. The DON verified allegation was not reported immediately. On 8/16/21, at 12:56 p.m. RN-B was interviewed and verified she was informed of the allegation by TR-A and did not report it. RN-B stated she meant to report it but "things got a little busy at work and I forgot." RN-B verified allegations of abuse and neglect should be reported immediately. The facility policy Vulnerable adult-MN dated 10/31/19, directed all staff, family members, volunteers and residents must report suspected/alleged abuse, neglect, exploitation of residents, mistreatment of residents, and/or misappropriation of resident property immediately. Each employee is responsible to report suspected/alleged violations immediately, but no later than 2 hours after the allegation is made.	F 609			
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684			

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F 684	Continued From page 5 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify and report a significant change of condition to the resident's medical provider, and the resident's representative in a timely manner for 1 of 3 residents (R1) reviewed for a change in condition. This resulted in an immediate jeopardy (IJ). The IJ began on 7/29/21, at 7:45 a.m. when nursing assistant (NA)-A found R1 unresponsive. NA-A reported this to registered nurse (RN)-A, who stated it could be a stroke. RN-A did not conduct a thorough assessment of R1, and did not contact R1's nurse practitioner (NP)-A to report R1 was unresponsive until 10:14 a.m., and at that time did not give full report that R1 was not responding. In addition, RN-A failed to notify R1's family on the change in condition. R1 was transported to the hospital at 3:20 p.m. at the request of R1's family. R1 died on 8/2/21. The administrator and the director of nursing (DON) were notified of the IJ on 8/12/21, at 2:25 p.m.. The IJ was removed on 8/13/21, at 2:59 p.m. but non-compliance remained at the lower scope and severity of a D, potential for more than minimal harm. Findings include:	F 684			

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F 684	Continued From page 6 R1's Face Sheet printed 8/16/21, indicated R1's diagnoses included fracture of fifth metatarsal bone of the right foot, Parkinson's disease, and congestive heart failure (CHF). R1's admission Minimum Data Set (MDS) dated 5/26/21, indicated R1 was cognitively intact, utilized a wheelchair, and required extensive assistance with most activities of daily living (ADLs). R1's care plan dated 5/21/21, indicated R1 made herself understood and understood others. R1's care plan further directed staff to monitor for changes in condition, and notify provider and resident representative as indicated. On 7/29/21, at 3:25 p.m. a progress note indicated R1 had been lethargic and unresponsive throughout the shift. RN-A had checked on R1 several times throughout the shift. R1's vitals were taken and were normal. NP-A had been notified and requested a blood sugar check. If the check was normal, call back later in the shift if R1 continued to be lethargic. R1's blood sugar was 120. R1's family member (FM)-A arrived sometime after noon and were concerned about R1. RN-A called NP-A again, noting R1 had not improved, and family was concerned. While awaiting return call from NP-A, FM-A requested R1 be sent in to the emergency department (ED). 911 was called to transfer R1, who left the facility at 3:20 p.m.. R1's medical record lacked any indication of a change in condition prior to the progress note entered at 3:25 p.m. on 7/29/21. On 7/29/21, at 11:36 p.m. a progress note	F 684			

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F 684	Continued From page 7 indicated FM-A was called and R1's condition was discussed. FM-A stated R1 had a major stroke, had a poor prognosis, and FM-A had been told R1's condition was "terminal." R1's United Hospital Emergency Room Notes dated 7/29/21, indicated R1 was unresponsive to physical or verbal stimulation. R1 had difficulty clearing secretions in the back of her oropharynx (throat) and had acute right-sided hemiparesis (weakness on one side of the body). R1 was found to have "a very large left-sided ACA (anterior cerebral artery) and MCA (middle cerebral artery) stroke, not recoverable." Genevieve Triage Call Log (log indicating when NP-A had been contacted) indicated two calls were received from RN-A to NP-A regarding R1. The first call was on 7/29/21, at 10:14 a.m. and the second call was on 7/29/21, at 2:13 p.m.. On 8/11/21, at 11:10 a.m. FM-A was interviewed and stated he went to visit R1 at approximately 2:00 p.m. on 7/29/21. FM-A stated R1 was lying in bed, with her lunch tray unopened on the bedside table which was "unusual" as R1 was always up. FM-A stated he attempted to waken R1 and could not. FM-A stated he went to the nurse's station and spoke with RN-A, who told him he had previously checked R1's vital signs, and R1 had been tired all day. FM-A returned to R1's room and attempted to awaken her again and could not. FM-A stated he returned to RN-A asked if NP-A had been called. FM-A stated he attempted to find another staff member to assess R1 and could not. FM-A stated he again went to RN-A and asked for a nurse manager. FM-A stated RN-A told him the RN managers were in care conferences. FM-A went to the first floor and with	F 684			

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F 684	Continued From page 8 the assistance of social service worker (SS)-A found RN-C in the hallway. RN-C and the DON went to speak with RN-A, and directed RN-A to conduct additional assessments. FM-A stated RN-A began taking R1's vital signs and assessing R1, and shortly after emergency medical services (EMS) arrived. FM-A stated when EMS arrived, they asked RN-A how R1 had been that morning and RN-A had stated "just like this." EMS stated to FM-A that R1 appeared to have had a stroke sometime in the night. When at the hospital, the ED staff told FM-A that R1 had a major stroke, most likely a terminal event. R1 passed away in the hospital on 8/2/21. On 8/11/21, at 2:02 p.m. RN-A was interviewed and stated on 7/29/21, NA-A approached him around 8:00 a.m. and stated R1 was still sleeping, and was not reactive to being changed. RN-A stated he worked with R1 the day before and she was up for breakfast. RN-A stated he had assessed R1 and she "appeared to be just sleeping" but was not responsive to verbal or physical stimulation. RN-A stated at approximately 9:00 a.m. he checked on R1 again, and she was still unresponsive. RN-A stated he took R1's vital signs, and attempted a pain stimulus check with no response. RN-A stated he called NP-A at approximately 9:30 a.m. and left a message with the triage line. RN-A stated about 30 minutes later the triage line called with instructions to take R1's blood sugar, attempt to get R1 up into her wheelchair, continue to monitor her, and call back if she did not become responsive. RN-A stated he felt that transferring R1 was unsafe and R1 "would have just slid out of the chair." RN-A stated he was unable to awaken R2 for lunch, which was abnormal as R1 would usually go to the dining room for meals.	F 684			

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F 684	Continued From page 9 RN-A stated FM-A arrived, and was concerned. RN-A explained he had called NP-A, went to check on her R1 again and she was still in the same position that she was in throughout the day. RN-A again called NP-A at approximately 1:30 p.m. and left a message that R1's condition had not changed. RN-A stated FM-A called the DON who came and instructed RN-A to conduct neuro-checks (used to assess an individual's neurological functions and level of consciousness to determine whether the individual is functioning properly and reacting appropriately to the tests) on R1. RN-A stated this was "the first time anyone mentioned a neuro-check." RN-A stated he completed the assessments and noted R1 was unresponsive to pain and unable to participate in neuro-checks. RN-A stated before receiving a return call from NP-A, FM-A requested R1 be sent to the hospital. RN-A stated he did not feel he could call 911 without doctors' or NP orders unless a resident was in dire, urgent need. RN-A stated he wanted assistance from a nurse manager but could not find them as they were in care conferences and "in the past I have been told not to bother them during care conferences." RN-A further stated, "Looking back, I should have called 911." On 8/11/21, at 2:33 p.m. NA-B was interviewed and stated she had worked with R1 on the evening of 7/28/21. NA-B stated she had provided R1 with an evening snack, assisted her in night cares, and got R1 into bed around 9:00 p.m. NA-B stated she checked on R1 around 9:30 p.m. before the end of her shift, and R1 indicated to NA-B that everything was fine. On 8/11/21, at 2:39 p.m. NA-A was interviewed and stated on 7/29/21, at about 7:30 a.m. she	F 684			

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F 684	Continued From page 10 observed R1 to have her eyes closed and was snoring. NA-A stated she attempted to awaken R1, but she was not responding. NA-A stated she attempted to reposition R1 onto her side to change her incontinent brief, but R1 was unable to participate in repositioning or gripping the side rail on her bed. NA-A stated she reported this to RN-A, who came to check R1's vital signs. When NA-A asked RN-A what was wrong with R1, RN-A stated he did not know and thought it could be a stroke, or she could be super sleepy. NA-A stated shortly after this she brought R1's breakfast tray in, and attempted to awaken R1 by shaking her and calling her name, but R1 was not responsive. NA-A stated she had not seen R1 like this in previous days. NA-A stated she continued to check on R1 and attempt to awaken her throughout the shift and "she was still like that." NA-A stated she asked RN-A how R1 was doing several times and RN-A told her he did not know yet. NA-A stated R1's condition had not improved throughout her shift. On 8/12/21, 10:19 a.m. RN-C was interviewed and stated she was in care conferences from about 1:00 p.m. until 2:30 p.m. on 7/29/21. RN-C stated SS-A approached her and stated there was a problem on the unit with R1. RN-C stated she went to R1's room and observed R1 lying in bed with her head slightly elevated, and eyes closed. RN-C stated RN-A was in the room attempting to take R1's vital signs. FM-A stated this was not R1's normal behavior, and RN-C immediately noticed a change in condition for R1 and stated, "I thought it was a stroke." RN-C stated RN-A told her he had called 911 per FM-A's request. RN-C was present when EMS arrived, and she heard EMS staff say R1 appeared to have had a stroke. RN-C stated EMS	F 684			

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F 684	Continued From page 11 asked RN-A how long R1 had been in that condition, and RN-A stated all shift. RN-C stated would have expected RN-A to inform her of a change in condition, and the family and medical provider also be informed right way. RN-C further stated she would expect staff to call 911 if concerns with a resident did not resolve and there was "always someone who is available" for nursing staff to consult with about resident concerns. On 8/12/21, at 10:36 a.m. the DON was interviewed. The DON stated on 7/29/21, at around 2:45 p.m. she was approached by SS-A and FM-A who informed her R1 was not waking up. The DON stated she went to speak with RN-A, who verified R1 was unresponsive, and also informed her he had contacted NP-A twice. The DON stated she instructed RN-A to conduct a neuro-assessment, check lung sounds, and vital signs. The DON stated she informed FM-A they could request for R1 to be sent into the hospital if they wanted treatment, which FM-A was in agreement with. The DON stated RN-A should have conducted a neurological assessment on R1 sooner. The DON stated while it was the common practice to get orders to call 911, staff could call 911 without orders, especially if family is requesting. The DON stated nurses have education on what to do if a resident has a change in condition. On 8/12/21, at 12:47 p.m. NP-A was interviewed and stated she received a message from R1 that staff was unable to awaken R1, and R1 was sleepy but comfortable. NP-A reviewed R1's medications and directed RN-A to take R1's blood sugar and vital signs. NP-A stated she did not recommend RN-A do neuro-checks on R1 as she	F 684			

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F 684	Continued From page 12 assumed RN-A had conducted neuro-checks as part of his initial assessment, and would have reported any abnormalities. NP-A stated she was not aware R1 was unresponsive, only that she was sleepy. NP-A stated it would have been helpful to have a more thorough assessment from RN-A to determine R1's needs. NP-A verified signs and symptoms of stroke include a change in mental status, weakness, impairment in walking or talking, total paralysis or weakness on one side, drooling, and drooping in the face. The facility policy Transfer of Resident to Hospital reviewed 12/9/19, directed: For life threatening emergencies: Check the resident's Code Status form/POLST/MOST, call 911, if indicated. Then notify physician and primary contact of the emergency and transfer. The facility policy Notification of Physician and Resident Representative revised 2/25/20, directed primary physicians, residents, and the resident representative, consistent with their authority, will be updated with all resident condition changes as soon as possible. The names of those contacted will be documented in the progress notes. The policy further directed If a physician is unavailable or does not respond in a timely manner, nurse will contact 911 if indicated. In the event of an emergency licensed staff have the discretion to transfer via 911 emergency services to the hospital. If the facility staff feel additional consultation is required concerning a resident's condition, a call would be placed to the director of nursing (or designee) and to the medical director. Additional notifications to home office staff would be made as indicated.	F 684			

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F 684	Continued From page 13 The facility policy Change in Condition revised 2/25/20, directed the nurse will notify the resident's attending physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition; Unless otherwise instructed by the resident, a nurse will notify the resident's representative when there is a significant change in the resident's physical, mental, or psychosocial status; Facility staff will also notify the RN in charge or the RN on call as indicated when changes in resident condition occur. The IJ was removed on 8/13/21, at 2:59 p.m. after it was verified through interview and document review the facility implemented a systemic plan of reeducation and policy change regarding change in condition.	F 684			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 31, 2021

Administrator
Augustana HCC Of Apple Valley
14650 Garrett Avenue
Apple Valley, MN 55124

Re: State Nursing Home Licensing Orders
Event ID: S9SW11

Dear Administrator:

The above facility was surveyed on August 11, 2021 through August 13, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

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

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit

Augustana HCC Of Apple Valley

August 31, 2021

Page 3

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: 00979	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/13/2021
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HCC OF APPLE VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
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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 8/11/21, through 8/13/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED with no licensing orders issued: H5264135C (MN75431), with a licensing order issued at 0265. The following complaint was found to be UNSUBSTANTIATED however, a related licensing order was issued at 1890: H5264136C (MN75386) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box	2 000		

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2 000	Continued From page 2 available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: 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, for example, a deterioration in health, mental, or psychosocial status in either life-threatening	2 265		

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2 265	Continued From page 3 conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to identify and report a significant change of condition to the resident's medical provider, and the resident's representative in a timely manner for 1 of 3 residents (R1) reviewed for a change in condition. This resulted in an immediate jeopardy (IJ). The IJ began on 7/29/21, at 7:45 a.m. when nursing assistant (NA)-A found R1 unresponsive. NA-A reported this to registered nurse (RN)-A, who stated it could be a stroke. RN-A did not conduct a thorough assessment of R1, and did not contact R1's nurse practitioner (NP)-A to report R1 was unresponsive until 10:14 a.m., and at that time did not give full report that R1 was not responding. In addition, RN-A failed to notify R1's family on the change in condition. R1 was transported to the hospital at 3:20 p.m. at the request of R1's family. R1 died on 8/2/21. The administrator and the director of nursing (DON) were notified of the IJ on 8/12/21, at 2:25 p.m.. The IJ was removed on 8/13/21, at 2:59 p.m. but non-compliance remained at the lower scope and severity of a D, potential for more than minimal	2 265			

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2 265	Continued From page 4 harm. Findings include: R1's Face Sheet printed 8/16/21, indicated R1's diagnoses included fracture of fifth metatarsal bone of the right foot, Parkinson's disease, and congestive heart failure (CHF). R1's admission Minimum Data Set (MDS) dated 5/26/21, indicated R1 was cognitively intact, utilized a wheelchair, and required extensive assistance with most activities of daily living (ADLs). R1's care plan dated 5/21/21, indicated R1 made herself understood and understood others. R1's care plan further directed staff to monitor for changes in condition, and notify provider and resident representative as indicated. On 7/29/21, at 3:25 p.m. a progress note indicated R1 had been lethargic and unresponsive throughout the shift. RN-A had checked on R1 several times throughout the shift. R1's vitals were taken and were normal. NP-A had been notified and requested a blood sugar check. If the check was normal, call back later in the shift if R1 continued to be lethargic. R1's blood sugar was 120. R1's family member (FM)-A arrived sometime after noon and were concerned about R1. RN-A called NP-A again, noting R1 had not improved, and family was concerned. While awaiting return call from NP-A, FM-A requested R1 be sent in to the emergency department (ED). 911 was called to transfer R1, who left the facility at 3:20 p.m.. R1's medical record lacked any indication of a change in condition prior to the progress note	2 265		

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2 265	Continued From page 5 entered at 3:25 p.m. on 7/29/21. On 7/29/21, at 11:36 p.m. a progress note indicated FM-A was called and R1's condition was discussed. FM-A stated R1 had a major stroke, had a poor prognosis, and FM-A had been told R1's condition was "terminal." R1's United Hospital Emergency Room Notes dated 7/29/21, indicated R1 was unresponsive to physical or verbal stimulation. R1 had difficulty clearing secretions in the back of her oropharynx (throat) and had acute right-sided hemiparesis (weakness on one side of the body). R1 was found to have "a very large left-sided ACA (anterior cerebral artery) and MCA (middle cerebral artery) stroke, not recoverable." Genevieve Triage Call Log (log indicating when NP-A had been contacted) indicated two calls were received from RN-A to NP-A regarding R1. The first call was on 7/29/21, at 10:14 a.m. and the second call was on 7/29/21, at 2:13 p.m.. On 8/11/21, at 11:10 a.m. FM-A was interviewed and stated he went to visit R1 at approximately 2:00 p.m. on 7/29/21. FM-A stated R1 was lying in bed, with her lunch tray unopened on the bedside table which was "unusual" as R1 was always up. FM-A stated he attempted to waken R1 and could not. FM-A stated he went to the nurse's station and spoke with RN-A, who told him he had previously checked R1's vital signs, and R1 had been tired all day. FM-A returned to R1's room and attempted to awaken her again and could not. FM-A stated he returned to RN-A asked if NP-A had been called. FM-A stated he attempted to find another staff member to assess R1 and could not. FM-A stated he again went to RN-A and asked for a nurse manager. FM-A stated	2 265		

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2 265	Continued From page 6 RN-A told him the RN managers were in care conferences. FM-A went to the first floor and with the assistance of social service worker (SS)-A found RN-C in the hallway. RN-C and the DON went to speak with RN-A, and directed RN-A to conduct additional assessments. FM-A stated RN-A began taking R1's vital signs and assessing R1, and shortly after emergency medical services (EMS) arrived. FM-A stated when EMS arrived, they asked RN-A how R1 had been that morning and RN-A had stated "just like this." EMS stated to FM-A that R1 appeared to have had a stroke sometime in the night. When at the hospital, the ED staff told FM-A that R1 had a major stroke, most likely a terminal event. R1 passed away in the hospital on 8/2/21. On 8/11/21, at 2:02 p.m. RN-A was interviewed and stated on 7/29/21, NA-A approached him around 8:00 a.m. and stated R1 was still sleeping, and was not reactive to being changed. RN-A stated he worked with R1 the day before and she was up for breakfast. RN-A stated he had assessed R1 and she "appeared to be just sleeping" but was not responsive to verbal or physical stimulation. RN-A stated at approximately 9:00 a.m. he checked on R1 again, and she was still unresponsive. RN-A stated he took R1's vital signs, and attempted a pain stimulus check with no response. RN-A stated he called NP-A at approximately 9:30 a.m. and left a message with the triage line. RN-A stated about 30 minutes later the triage line called with instructions to take R1's blood sugar, attempt to get R1 up into her wheelchair, continue to monitor her, and call back if she did not become responsive. RN-A stated he felt that transferring R1 was unsafe and R1 "would have just slid out of the chair." RN-A stated he was unable to awaken R2 for lunch, which was abnormal as R1	2 265			

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2 265	Continued From page 7 would usually go to the dining room for meals. RN-A stated FM-A arrived, and was concerned. RN-A explained he had called NP-A, went to check on her R1 again and she was still in the same position that she was in throughout the day. RN-A again called NP-A at approximately 1:30 p.m. and left a message that R1's condition had not changed. RN-A stated FM-A called the DON who came and instructed RN-A to conduct neuro-checks (used to assess an individual's neurological functions and level of consciousness to determine whether the individual is functioning properly and reacting appropriately to the tests) on R1. RN-A stated this was "the first time anyone mentioned a neuro-check." RN-A stated he completed the assessments and noted R1 was unresponsive to pain and unable to participate in neuro-checks. RN-A stated before receiving a return call from NP-A, FM-A requested R1 be sent to the hospital. RN-A stated he did not feel he could call 911 without doctors' or NP orders unless a resident was in dire, urgent need. RN-A stated he wanted assistance from a nurse manager but could not find them as they were in care conferences and "in the past I have been told not to bother them during care conferences." RN-A further stated, "Looking back, I should have called 911." On 8/11/21, at 2:33 p.m. NA-B was interviewed and stated she had worked with R1 on the evening of 7/28/21. NA-B stated she had provided R1 with an evening snack, assisted her in night cares, and got R1 into bed around 9:00 p.m. NA-B stated she checked on R1 around 9:30 p.m. before the end of her shift, and R1 indicated to NA-B that everything was fine. On 8/11/21, at 2:39 p.m. NA-A was interviewed and stated on 7/29/21, at about 7:30 a.m. she	2 265		

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2 265	Continued From page 8 observed R1 to have her eyes closed and was snoring. NA-A stated she attempted to awaken R1, but she was not responding. NA-A stated she attempted to reposition R1 onto her side to change her incontinent brief, but R1 was unable to participate in repositioning or gripping the side rail on her bed. NA-A stated she reported this to RN-A, who came to check R1's vital signs. When NA-A asked RN-A what was wrong with R1, RN-A stated he did not know and thought it could be a stroke, or she could be super sleepy. NA-A stated shortly after this she brought R1's breakfast tray in, and attempted to awaken R1 by shaking her and calling her name, but R1 was not responsive. NA-A stated she had not seen R1 like this in previous days. NA-A stated she continued to check on R1 and attempt to awaken her throughout the shift and "she was still like that." NA-A stated she asked RN-A how R1 was doing several times and RN-A told her he did not know yet. NA-A stated R1's condition had not improved throughout her shift. On 8/12/21, 10:19 a.m. RN-C was interviewed and stated she was in care conferences from about 1:00 p.m. until 2:30 p.m. on 7/29/21. RN-C stated SS-A approached her and stated there was a problem on the unit with R1. RN-C stated she went to R1's room and observed R1 lying in bed with her head slightly elevated, and eyes closed. RN-C stated RN-A was in the room attempting to take R1's vital signs. FM-A stated this was not R1's normal behavior, and RN-C immediately noticed a change in condition for R1 and stated, "I thought it was a stroke." RN-C stated RN-A told her he had called 911 per FM-A's request. RN-C was present when EMS arrived, and she heard EMS staff say R1 appeared to have had a stroke. RN-C stated EMS asked RN-A how long R1 had been in that	2 265			

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2 265	Continued From page 9 condition, and RN-A stated all shift. RN-C stated would have expected RN-A to inform her of a change in condition, and the family and medical provider also be informed right way. RN-C further stated she would expect staff to call 911 if concerns with a resident did not resolve and there was "always someone who is available" for nursing staff to consult with about resident concerns. On 8/12/21, at 10:36 a.m. the DON was interviewed. The DON stated on 7/29/21, at around 2:45 p.m. she was approached by SS-A and FM-A who informed her R1 was not waking up. The DON stated she went to speak with RN-A, who verified R1 was unresponsive, and also informed her he had contacted NP-A twice. The DON stated she instructed RN-A to conduct a neuro-assessment, check lung sounds, and vital signs. The DON stated she informed FM-A they could request for R1 to be sent into the hospital if they wanted treatment, which FM-A was in agreement with. The DON stated RN-A should have conducted a neurological assessment on R1 sooner. The DON stated while it was the common practice to get orders to call 911, staff could call 911 without orders, especially if family is requesting. The DON stated nurses have education on what to do if a resident has a change in condition. On 8/12/21, at 12:47 p.m. NP-A was interviewed and stated she received a message from R1 that staff was unable to awaken R1, and R1 was sleepy but comfortable. NP-A reviewed R1's medications and directed RN-A to take R1's blood sugar and vital signs. NP-A stated she did not recommend RN-A do neuro-checks on R1 as she assumed RN-A had conducted neuro-checks as part of his initial assessment, and would have	2 265			

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2 265	Continued From page 10 reported any abnormalities. NP-A stated she was not aware R1 was unresponsive, only that she was sleepy. NP-A stated it would have been helpful to have a more thorough assessment from RN-A to determine R1's needs. NP-A verified signs and symptoms of stroke include a change in mental status, weakness, impairment in walking or talking, total paralysis or weakness on one side, drooling, and drooping in the face. The facility policy Transfer of Resident to Hospital reviewed 12/9/19, directed: For life threatening emergencies: Check the resident's Code Status form/POLST/MOST, call 911, if indicated. Then notify physician and primary contact of the emergency and transfer. The facility policy Notification of Physician and Resident Representative revised 2/25/20, directed primary physicians, residents, and the resident representative, consistent with their authority, will be updated with all resident condition changes as soon as possible. The names of those contacted will be documented in the progress notes. The policy further directed If a physician is unavailable or does not respond in a timely manner, nurse will contact 911 if indicated. In the event of an emergency licensed staff have the discretion to transfer via 911 emergency services to the hospital. If the facility staff feel additional consultation is required concerning a resident's condition, a call would be placed to the director of nursing (or designee) and to the medical director. Additional notifications to home office staff would be made as indicated. The facility policy Change in Condition revised 2/25/20, directed the nurse will notify the resident's attending physician or physician on call	2 265		

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2 265	Continued From page 11 when there has been a significant change in the resident's physical/emotional/mental condition; Unless otherwise instructed by the resident, a nurse will notify the resident's representative when there is a significant change in the resident's physical, mental, or psychosocial status; Facility staff will also notify the RN in charge or the RN on call as indicated when changes in resident condition occur. The IJ was removed on 8/13/21, at 2:59 p.m. after it was verified through interview and document review the facility implemented a systemic plan of reeducation and policy change regarding change in condition. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies to providers and family members are notified when a resident has a change of condition. The DON or designee could educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265			
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not	21980			

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21980	Continued From page 12 reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause	21980		

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21980	Continued From page 13 (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the State Agency (SA) was notified immediately (within 2 hours) of an allegation of physical abuse involving 2 of 3 residents (R2, R3) reviewed for allegations of abuse. Findings include: R2's Face Sheet printed 8/13/21, indicated R2's diagnoses included alcohol abuse, history of falling, and chronic kidney disease. R2's admission Minimum Data Set (MDS) dated 6/3/21, indicated R2 was cognitively intact and required limited assistance with most activities of daily living (ADLs). R2's care plan dated 6/1/21, indicated R2 was at risk for abuse/neglect due to vulnerable status living in an nursing home and would remain safe and free from abuse. R3's Face Sheet printed 8/13/21, indicated R3's diagnosis included major depressive disorder, personality disorder, and dementia with behavioral disturbance. R3's quarterly MDS dated 5/12/21, indicated R3 had a moderate cognitive impairment and required extensive assistance with most ADLs. R3's care plan dated 7/31/21, indicated R3 had	21980			

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21980	Continued From page 14 mood concerns and history of hitting staff, throwing objects at staff, and verbally abusing staff. The care plan also indicated R3 threatened to throw things at other residents when they went past his room. R3 was to have 1 on 1 staff supervision when he was out of bed and present at facility. On 7/30/21, at 4:16 p.m. a progress note indicated R2 stated another resident [R3] had been yelling and swearing at her while she was near the front desk trying to pass by him. R2 stated that [R3] kicked her in the left leg, and that it hurt for a while. The incident was immediately reported to the floor nurse. On 7/31/21, at 11:41 a.m. a progress note indicated follow up from note on 7/30/21. No injury observed to [R2]. No redness, no bruising, no skin tears, no warmth, or tenderness to the touch present to R2's left shin. [R2] reported she feels safe in the facility. Director of nursing (DON) and administrator updated. On 7/31/21, at 11:42 a.m. a progress note indicated 1 on 1 supervision was implemented for R3 when he was out of bed. R3's care plan was updated. On 8/11/21, at 9:47 a.m. R2 was interviewed and stated there was an ongoing issue when she encountered R3. R2 stated R3 had "wheeled up to me and gave me a kick in the shin." R2 stated she reported this to therapeutic recreation aide (TR)-A. On 8/11/21, at 10:30 a.m. TR-A was interviewed and stated he spoke with R2 on 7/30/21, and she "looked a little distraught." R2 stated R3 had sworn at her and kicked her as well. TR-A stated	21980		

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21980	Continued From page 15 he had reported this to registered nurse (RN)-B, who "didn't say much." On 8/11/21, at 10:55 a.m. RN-A was interviewed and stated he discovered TR-A's progress note regarding R2's abuse allegation on 7/31/21. RN-A placed a call to the DON who indicated the allegation had not been addressed. RN-A initialed an investigation and reported to alleged abuse to the SA. RN-A stated the allegation should have should have been reported immediately. On 8/11/21, at 1:43 p.m. the DON was interviewed and verified all facility staff were mandated reporters, and allegations should initially be reported to the direct supervisor immediately. The DON verified allegation was not reported immediately. On 8/16/21, at 12:56 p.m. RN-B was interviewed and verified she was informed of the allegation by TR-A and did not report it. RN-B stated she meant to report it but "things got a little busy at work and I forgot." RN-B verified allegations of abuse and neglect should be reported immediately. The facility policy Vulnerable adult-MN dated 10/31/19, directed all staff, family members, volunteers and residents must report suspected/alleged abuse, neglect, exploitation of residents, mistreatment of residents, and/or misappropriation of resident property immediately. Each employee is responsible to report suspected/alleged violations immediately, but no later than 2 hours after the allegation is made. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and	21980		

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21980	Continued From page 16 revise policies to ensure allegations of abuse are reported immediately (within two hours) to the SA. The administrator or designee could educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21980			

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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 8/11/21, through 8/13/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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

TITLE

(X6) DATE

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED with no licensing orders issued: H5264135C (MN75431), with a licensing order issued at 0265. The following complaint was found to be UNSUBSTANTIATED however, a related licensing order was issued at 1890: H5264136C (MN75386) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box	2 000		

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2 000	Continued From page 2 available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: 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, for example, a deterioration in health, mental, or psychosocial status in either life-threatening	2 265		

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2 265	Continued From page 3 conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to identify and report a significant change of condition to the resident's medical provider, and the resident's representative in a timely manner for 1 of 3 residents (R1) reviewed for a change in condition. This resulted in an immediate jeopardy (IJ). The IJ began on 7/29/21, at 7:45 a.m. when nursing assistant (NA)-A found R1 unresponsive. NA-A reported this to registered nurse (RN)-A, who stated it could be a stroke. RN-A did not conduct a thorough assessment of R1, and did not contact R1's nurse practitioner (NP)-A to report R1 was unresponsive until 10:14 a.m., and at that time did not give full report that R1 was not responding. In addition, RN-A failed to notify R1's family on the change in condition. R1 was transported to the hospital at 3:20 p.m. at the request of R1's family. R1 died on 8/2/21. The administrator and the director of nursing (DON) were notified of the IJ on 8/12/21, at 2:25 p.m.. The IJ was removed on 8/13/21, at 2:59 p.m. but non-compliance remained at the lower scope and severity of a D, potential for more than minimal	2 265		

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2 265	Continued From page 4 harm. Findings include: R1's Face Sheet printed 8/16/21, indicated R1's diagnoses included fracture of fifth metatarsal bone of the right foot, Parkinson's disease, and congestive heart failure (CHF). R1's admission Minimum Data Set (MDS) dated 5/26/21, indicated R1 was cognitively intact, utilized a wheelchair, and required extensive assistance with most activities of daily living (ADLs). R1's care plan dated 5/21/21, indicated R1 made herself understood and understood others. R1's care plan further directed staff to monitor for changes in condition, and notify provider and resident representative as indicated. On 7/29/21, at 3:25 p.m. a progress note indicated R1 had been lethargic and unresponsive throughout the shift. RN-A had checked on R1 several times throughout the shift. R1's vitals were taken and were normal. NP-A had been notified and requested a blood sugar check. If the check was normal, call back later in the shift if R1 continued to be lethargic. R1's blood sugar was 120. R1's family member (FM)-A arrived sometime after noon and were concerned about R1. RN-A called NP-A again, noting R1 had not improved, and family was concerned. While awaiting return call from NP-A, FM-A requested R1 be sent in to the emergency department (ED). 911 was called to transfer R1, who left the facility at 3:20 p.m.. R1's medical record lacked any indication of a change in condition prior to the progress note	2 265		

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2 265	Continued From page 5 entered at 3:25 p.m. on 7/29/21. On 7/29/21, at 11:36 p.m. a progress note indicated FM-A was called and R1's condition was discussed. FM-A stated R1 had a major stroke, had a poor prognosis, and FM-A had been told R1's condition was "terminal." R1's United Hospital Emergency Room Notes dated 7/29/21, indicated R1 was unresponsive to physical or verbal stimulation. R1 had difficulty clearing secretions in the back of her oropharynx (throat) and had acute right-sided hemiparesis (weakness on one side of the body). R1 was found to have "a very large left-sided ACA (anterior cerebral artery) and MCA (middle cerebral artery) stroke, not recoverable." Genevieve Triage Call Log (log indicating when NP-A had been contacted) indicated two calls were received from RN-A to NP-A regarding R1. The first call was on 7/29/21, at 10:14 a.m. and the second call was on 7/29/21, at 2:13 p.m.. On 8/11/21, at 11:10 a.m. FM-A was interviewed and stated he went to visit R1 at approximately 2:00 p.m. on 7/29/21. FM-A stated R1 was lying in bed, with her lunch tray unopened on the bedside table which was "unusual" as R1 was always up. FM-A stated he attempted to waken R1 and could not. FM-A stated he went to the nurse's station and spoke with RN-A, who told him he had previously checked R1's vital signs, and R1 had been tired all day. FM-A returned to R1's room and attempted to awaken her again and could not. FM-A stated he returned to RN-A asked if NP-A had been called. FM-A stated he attempted to find another staff member to assess R1 and could not. FM-A stated he again went to RN-A and asked for a nurse manager. FM-A stated	2 265		

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2 265	Continued From page 6 RN-A told him the RN managers were in care conferences. FM-A went to the first floor and with the assistance of social service worker (SS)-A found RN-C in the hallway. RN-C and the DON went to speak with RN-A, and directed RN-A to conduct additional assessments. FM-A stated RN-A began taking R1's vital signs and assessing R1, and shortly after emergency medical services (EMS) arrived. FM-A stated when EMS arrived, they asked RN-A how R1 had been that morning and RN-A had stated "just like this." EMS stated to FM-A that R1 appeared to have had a stroke sometime in the night. When at the hospital, the ED staff told FM-A that R1 had a major stroke, most likely a terminal event. R1 passed away in the hospital on 8/2/21. On 8/11/21, at 2:02 p.m. RN-A was interviewed and stated on 7/29/21, NA-A approached him around 8:00 a.m. and stated R1 was still sleeping, and was not reactive to being changed. RN-A stated he worked with R1 the day before and she was up for breakfast. RN-A stated he had assessed R1 and she "appeared to be just sleeping" but was not responsive to verbal or physical stimulation. RN-A stated at approximately 9:00 a.m. he checked on R1 again, and she was still unresponsive. RN-A stated he took R1's vital signs, and attempted a pain stimulus check with no response. RN-A stated he called NP-A at approximately 9:30 a.m. and left a message with the triage line. RN-A stated about 30 minutes later the triage line called with instructions to take R1's blood sugar, attempt to get R1 up into her wheelchair, continue to monitor her, and call back if she did not become responsive. RN-A stated he felt that transferring R1 was unsafe and R1 "would have just slid out of the chair." RN-A stated he was unable to awaken R2 for lunch, which was abnormal as R1	2 265		

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2 265	Continued From page 7 would usually go to the dining room for meals. RN-A stated FM-A arrived, and was concerned. RN-A explained he had called NP-A, went to check on her R1 again and she was still in the same position that she was in throughout the day. RN-A again called NP-A at approximately 1:30 p.m. and left a message that R1's condition had not changed. RN-A stated FM-A called the DON who came and instructed RN-A to conduct neuro-checks (used to assess an individual's neurological functions and level of consciousness to determine whether the individual is functioning properly and reacting appropriately to the tests) on R1. RN-A stated this was "the first time anyone mentioned a neuro-check." RN-A stated he completed the assessments and noted R1 was unresponsive to pain and unable to participate in neuro-checks. RN-A stated before receiving a return call from NP-A, FM-A requested R1 be sent to the hospital. RN-A stated he did not feel he could call 911 without doctors' or NP orders unless a resident was in dire, urgent need. RN-A stated he wanted assistance from a nurse manager but could not find them as they were in care conferences and "in the past I have been told not to bother them during care conferences." RN-A further stated, "Looking back, I should have called 911." On 8/11/21, at 2:33 p.m. NA-B was interviewed and stated she had worked with R1 on the evening of 7/28/21. NA-B stated she had provided R1 with an evening snack, assisted her in night cares, and got R1 into bed around 9:00 p.m. NA-B stated she checked on R1 around 9:30 p.m. before the end of her shift, and R1 indicated to NA-B that everything was fine. On 8/11/21, at 2:39 p.m. NA-A was interviewed and stated on 7/29/21, at about 7:30 a.m. she	2 265		

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2 265	Continued From page 8 observed R1 to have her eyes closed and was snoring. NA-A stated she attempted to awaken R1, but she was not responding. NA-A stated she attempted to reposition R1 onto her side to change her incontinent brief, but R1 was unable to participate in repositioning or gripping the side rail on her bed. NA-A stated she reported this to RN-A, who came to check R1's vital signs. When NA-A asked RN-A what was wrong with R1, RN-A stated he did not know and thought it could be a stroke, or she could be super sleepy. NA-A stated shortly after this she brought R1's breakfast tray in, and attempted to awaken R1 by shaking her and calling her name, but R1 was not responsive. NA-A stated she had not seen R1 like this in previous days. NA-A stated she continued to check on R1 and attempt to awaken her throughout the shift and "she was still like that." NA-A stated she asked RN-A how R1 was doing several times and RN-A told her he did not know yet. NA-A stated R1's condition had not improved throughout her shift. On 8/12/21, 10:19 a.m. RN-C was interviewed and stated she was in care conferences from about 1:00 p.m. until 2:30 p.m. on 7/29/21. RN-C stated SS-A approached her and stated there was a problem on the unit with R1. RN-C stated she went to R1's room and observed R1 lying in bed with her head slightly elevated, and eyes closed. RN-C stated RN-A was in the room attempting to take R1's vital signs. FM-A stated this was not R1's normal behavior, and RN-C immediately noticed a change in condition for R1 and stated, "I thought it was a stroke." RN-C stated RN-A told her he had called 911 per FM-A's request. RN-C was present when EMS arrived, and she heard EMS staff say R1 appeared to have had a stroke. RN-C stated EMS asked RN-A how long R1 had been in that	2 265		

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2 265	Continued From page 9 condition, and RN-A stated all shift. RN-C stated would have expected RN-A to inform her of a change in condition, and the family and medical provider also be informed right way. RN-C further stated she would expect staff to call 911 if concerns with a resident did not resolve and there was "always someone who is available" for nursing staff to consult with about resident concerns. On 8/12/21, at 10:36 a.m. the DON was interviewed. The DON stated on 7/29/21, at around 2:45 p.m. she was approached by SS-A and FM-A who informed her R1 was not waking up. The DON stated she went to speak with RN-A, who verified R1 was unresponsive, and also informed her he had contacted NP-A twice. The DON stated she instructed RN-A to conduct a neuro-assessment, check lung sounds, and vital signs. The DON stated she informed FM-A they could request for R1 to be sent into the hospital if they wanted treatment, which FM-A was in agreement with. The DON stated RN-A should have conducted a neurological assessment on R1 sooner. The DON stated while it was the common practice to get orders to call 911, staff could call 911 without orders, especially if family is requesting. The DON stated nurses have education on what to do if a resident has a change in condition. On 8/12/21, at 12:47 p.m. NP-A was interviewed and stated she received a message from R1 that staff was unable to awaken R1, and R1 was sleepy but comfortable. NP-A reviewed R1's medications and directed RN-A to take R1's blood sugar and vital signs. NP-A stated she did not recommend RN-A do neuro-checks on R1 as she assumed RN-A had conducted neuro-checks as part of his initial assessment, and would have	2 265		

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2 265	Continued From page 10 reported any abnormalities. NP-A stated she was not aware R1 was unresponsive, only that she was sleepy. NP-A stated it would have been helpful to have a more thorough assessment from RN-A to determine R1's needs. NP-A verified signs and symptoms of stroke include a change in mental status, weakness, impairment in walking or talking, total paralysis or weakness on one side, drooling, and drooping in the face. The facility policy Transfer of Resident to Hospital reviewed 12/9/19, directed: For life threatening emergencies: Check the resident's Code Status form/POLST/MOST, call 911, if indicated. Then notify physician and primary contact of the emergency and transfer. The facility policy Notification of Physician and Resident Representative revised 2/25/20, directed primary physicians, residents, and the resident representative, consistent with their authority, will be updated with all resident condition changes as soon as possible. The names of those contacted will be documented in the progress notes. The policy further directed If a physician is unavailable or does not respond in a timely manner, nurse will contact 911 if indicated. In the event of an emergency licensed staff have the discretion to transfer via 911 emergency services to the hospital. If the facility staff feel additional consultation is required concerning a resident's condition, a call would be placed to the director of nursing (or designee) and to the medical director. Additional notifications to home office staff would be made as indicated. The facility policy Change in Condition revised 2/25/20, directed the nurse will notify the resident's attending physician or physician on call	2 265		

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2 265	Continued From page 11 when there has been a significant change in the resident's physical/emotional/mental condition; Unless otherwise instructed by the resident, a nurse will notify the resident's representative when there is a significant change in the resident's physical, mental, or psychosocial status; Facility staff will also notify the RN in charge or the RN on call as indicated when changes in resident condition occur. The IJ was removed on 8/13/21, at 2:59 p.m. after it was verified through interview and document review the facility implemented a systemic plan of reeducation and policy change regarding change in condition. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies to providers and family members are notified when a resident has a change of condition. The DON or designee could educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265			
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not	21980			

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21980	Continued From page 12 reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause	21980		

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21980	Continued From page 13 (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the State Agency (SA) was notified immediately (within 2 hours) of an allegation of physical abuse involving 2 of 3 residents (R2, R3) reviewed for allegations of abuse. Findings include: R2's Face Sheet printed 8/13/21, indicated R2's diagnoses included alcohol abuse, history of falling, and chronic kidney disease. R2's admission Minimum Data Set (MDS) dated 6/3/21, indicated R2 was cognitively intact and required limited assistance with most activities of daily living (ADLs). R2's care plan dated 6/1/21, indicated R2 was at risk for abuse/neglect due to vulnerable status living in an nursing home and would remain safe and free from abuse. R3's Face Sheet printed 8/13/21, indicated R3's diagnosis included major depressive disorder, personality disorder, and dementia with behavioral disturbance. R3's quarterly MDS dated 5/12/21, indicated R3 had a moderate cognitive impairment and required extensive assistance with most ADLs. R3's care plan dated 7/31/21, indicated R3 had	21980		

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21980	Continued From page 14 mood concerns and history of hitting staff, throwing objects at staff, and verbally abusing staff. The care plan also indicated R3 threatened to throw things at other residents when they went past his room. R3 was to have 1 on 1 staff supervision when he was out of bed and present at facility. On 7/30/21, at 4:16 p.m. a progress note indicated R2 stated another resident [R3] had been yelling and swearing at her while she was near the front desk trying to pass by him. R2 stated that [R3] kicked her in the left leg, and that it hurt for a while. The incident was immediately reported to the floor nurse. On 7/31/21, at 11:41 a.m. a progress note indicated follow up from note on 7/30/21. No injury observed to [R2]. No redness, no bruising, no skin tears, no warmth, or tenderness to the touch present to R2's left shin. [R2] reported she feels safe in the facility. Director of nursing (DON) and administrator updated. On 7/31/21, at 11:42 a.m. a progress note indicated 1 on 1 supervision was implemented for R3 when he was out of bed. R3's care plan was updated. On 8/11/21, at 9:47 a.m. R2 was interviewed and stated there was an ongoing issue when she encountered R3. R2 stated R3 had "wheeled up to me and gave me a kick in the shin." R2 stated she reported this to therapeutic recreation aide (TR)-A. On 8/11/21, at 10:30 a.m. TR-A was interviewed and stated he spoke with R2 on 7/30/21, and she "looked a little distraught." R2 stated R3 had sworn at her and kicked her as well. TR-A stated	21980		

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21980	Continued From page 15 he had reported this to registered nurse (RN)-B, who "didn't say much." On 8/11/21, at 10:55 a.m. RN-A was interviewed and stated he discovered TR-A's progress note regarding R2's abuse allegation on 7/31/21. RN-A placed a call to the DON who indicated the allegation had not been addressed. RN-A initialed an investigation and reported to alleged abuse to the SA. RN-A stated the allegation should have should have been reported immediately. On 8/11/21, at 1:43 p.m. the DON was interviewed and verified all facility staff were mandated reporters, and allegations should initially be reported to the direct supervisor immediately. The DON verified allegation was not reported immediately. On 8/16/21, at 12:56 p.m. RN-B was interviewed and verified she was informed of the allegation by TR-A and did not report it. RN-B stated she meant to report it but "things got a little busy at work and I forgot." RN-B verified allegations of abuse and neglect should be reported immediately. The facility policy Vulnerable adult-MN dated 10/31/19, directed all staff, family members, volunteers and residents must report suspected/alleged abuse, neglect, exploitation of residents, mistreatment of residents, and/or misappropriation of resident property immediately. Each employee is responsible to report suspected/alleged violations immediately, but no later than 2 hours after the allegation is made. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and	21980			

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21980	Continued From page 16 revise policies to ensure allegations of abuse are reported immediately (within two hours) to the SA. The administrator or designee could educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21980			