Electronically delivered
January 25, 2022

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

RE: CCN: 245264
Cycle Start Date: January 13, 2022

Dear Administrator:

On January 13, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

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

DEPARTMENT CONTACT

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

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 13, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 13, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	C 01/13/2022

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AUGUSTANA HCC OF APPLE VALLEY	**14650 GARRETT AVENUE APPLE VALLEY, MN 55124**

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F 000	INITIAL COMMENTS On 1/12/22 to 1/13/22, an abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH) to conduct complaint investigations. Augustana of Apple Valley was found to not be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5264161C (MN79751); with non-compliance cited at F550, F585, and F677. H5264162C (MN80026); with non-compliance cited at F550. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Though no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and	F 550		

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

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F 550	Continued From page 1 outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely	F 550		

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F 550	Continued From page 2	F 550		

assistance was provided when care was requested to promote a dignified existence for 2 of 3 residents (R1, R3) reviewed who expressed concerns with extended call light responses times.

Findings include:

R1's Face Sheet dated 1/13/22, indicated R1 had diagnoses of scoliosis (sideways curvature of the spine), intervertebral disc degeneration of the lumbar region (age-related wear and tear on a spinal disc causes low back pain), low back pain, and had spinal surgery of fusion of spinal bones and lamina, discs, or facets (surgery to permanently connect two or more vertebrae in your spine).

R1's admission Minimum Data Set (MDS), dated 10/25/21, identified R1 had a moderate cognitive impairment and required extensive assistance of one staff with most of his activities of daily living (ADLs).

During an interview with family member (FM)-A on 1/12/22, at 10:00 a.m. FM-A stated R1 had been frustrated due to how long he had waited for his call light to be answered. FM-A stated long call light times occur during the night and day.

Review of R1's Call Light Report dated 12/20/21, to 1/12/22, indicated R1 had 15 occurrences in which his wait time for call light light response ranged from 15 minutes to 36 minutes.

During an interview with registered nurse case manager (RNCM) on 1/12/22, at 10:26 a.m. she stated long call light times was a concern for R1. RNCM stated long call light times put R1 at risk

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F 550	Continued From page 3	F 550		

for uncontrolled pain or put his safety at risk. RNCM stated she was aware of two situations where R1 put on his call light and waited more than 20 minutes for assistance.

During an interview with R1 on 1/12/22, at 12:00 p.m. R1 stated he had reported his concerns to the facility social worker regarding long call light times. R1 stated on multiple occasions, he waited more than 25 minutes for someone to answer his call light and get pain relief.

During an interview on 1/12/22, at 1:11 p.m. social worker (SW)-A stated R1 did complain a few times regarding long call light response times on 12/21/21, and 1/22/22, when he experienced severe pain and needed pain medication.

R3's annual MDS dated 12/29/21, indicated R3 was cognitively intact and required extensive assistance with bed mobility and personal hygiene.

R3's care plan dated 1/11/22, indicated R3 had a problem with ADL function and was able to use the call light to make her needs known.

Review of R3's Call Light Report dated 12/1/21, to 12/16/21, indicated there were 19 occurrences in which wait times ranged from 23 minutes up to one hour and 44 minutes. There were nine occurrences in which R3 waited from 15 minutes to 22 minutes.

Review of R3's Call Light Report dated 12/16/21, to 1/11/22, indicated there were 54 occurrences in which wait times ranged from 20 minutes up to one hour. There were 24 occurrences in which R3 waited for over 40 minutes.

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F 550	Continued From page 4 During review of security camera footage (outside of R3's room pointing towards the end of the hall) dated 12/22/21, R3's call light was observed flashing from 10:37 p.m. to 11:03 p.m. for roughly 24 minutes. Three staff were seen within 20 feet of R3's room, however, did not enter R3's room. A male employee was seen with his back to R3's room and was talking to two female employees. One of the female employees had a three tiered cart with gloves and other supplies and the other female employee handed the male employee a cell phone. During an interview with R3 on 1/13/22, at 11:16 a.m. she stated she had long call light wait times and required assistance going to the bathroom. R3 stated due to the long call light times she was becoming more incontinent which was embarrassing. R3 stated she waited for assistance for 30 minutes to up to one and one-half hours and added, "I just cannot always wait that long." During an interview on 1/13/22, at 12:42 p.m. SW-C stated R3 did express concerns to her regarding long call light times. SW-C stated other resident's had complained about long call light times and it was her expectation for staff to respond and see what a resident needed. During an interview on 1/13/22, at 1:15 p.m. (FM)-B stated R3 complained to the facility regarding long call light times and and waiting for assistance to use the bathroom in the past. FM-B expressed she understood the facility may be short staffed, however, resident should not have to wait 30 minutes for help to the bathroom.	F 550		

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F 550	Continued From page 5 During an interview with the director of nursing (DON) on 1/13/22, at 2:30 p.m. the DON stated it was the responsibility of all staff at the facility to respond to call lights. The DON stated she reviewed the security footage (12/22/21) and she was able to see R3's call light go on and three staff were within roughly 20 feet of R3's door, however, no one responded to the call light. She stated she was appalled and the care would be considered substandard when she reviewed the call light log for R3. The DON stated her expectation was for call lights to be answered within five minutes or as soon as possible. Facility policy titled Call Lights, dated 12/31/18, indicated it was the responsibility of all staff from all departments to respond to the call light and either assist with request for obtain assistance from the appropriate staff to meet the residents need. The policy further indicated call lights were responded to as soon as possible.	F 550		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to	F 585		

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F 585	Continued From page 6 resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those	F 585		

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F 585	Continued From page 7 grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by:	F 585		

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Based on interview and document review, the facility failed to ensure a voiced grievance concerning call light response times was addressed and resolved to satisfaction for 1 of 1 resident (R1) who reported increased pain due to waiting extended periods for call light response.

Findings include:

R1's admission Minimum Data Set (MDS), dated 10/25/21, identified R1 had moderate cognitive impairment and required extensive assistance of one staff with most of his activities of daily living (ADLs). Further, the MDS outlined R2 received both scheduled and as needed (PRN) medication for pain relief. R1 voiced pain almost constantly described as "severe," limited day to day activities, and made it hard to for R1 to sleep at night.

During an interview with R1 on 1/12/22, at 12:00 p.m. R1 stated he had reported multiple times to registered nurse (RN)-A and to social worker (SW)-A concerns regarding long call light wait times.

Review of the facility's December 2021 and January 2022 Grievance Logs lacked indication of R1's expressed concern.

During an interview on 1/12/22, at 1:11 p.m. SW-A confirmed she met with R1 who had voiced concerns regarding long wait times During December and January. SW-A stated R1 had verbalized he was using the call light due to severe pain and needing medications. SW-A confirmed she did not file a grievance regarding R1's concern for long call light times.

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F 585	Continued From page 9 When interviewed on 1/13/22, at 12:58 p.m. the social service director (SSD) stated it is the responsibility of staff to report concerns even if R1 requested to remain anonymous to ensure his grievance. SSD expressed SW-A should had completed a grievance form when R1 complained of long call light response times so it could be routed to the correct person to be addressed. SSD stated her expectation would include all social workers informing the residents of their right to file a grievance upon admission, assist residents with writing grievances, and complete a grievance form for each grievance. The facility's Vulnerable Adult policy, dated 11/21/18, indicated all staff should treat each resident with respect and dignity, and staff were to provide required goods and services to residents which were necessary to avoid pain. Further, the policy indicated the facility would provide information to the resident and family with how to file a grievance.	F 585		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure assistance was provided with routine grooming and personal hygiene for 1 of 3 residents (R3) reviewed for activities of daily living (ADLs) and who was dependent on staff for care.	F 677		

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F 677	Continued From page 10 Findings include: R3's annual Minimum Data Set (MDS), dated 12/29/21, indicated R3 was cognitively intact and demonstrated no behavior(s). Further, the MDS identified R3 required extensive assistance for their bed mobility and personal hygiene. R3's care plan dated 1/1/22, indicated R3 had a problem with ADL function and required assistance with grooming related to dementia and weakness. R3's care plan directed staff to assist resident with grooming. On 1/13/22, at 11:16 a.m. R3 was observed laying in bed. R3 had visibly long nails present on both hands and several nails had a visible tan/brown colored substance underneath. Multiple nails were curled underneath on the side. In addition, R3's hair appeared uncombed with and appeared greasy. Further, R3 had visible black-colored facial hair present on her upper lip and chin which ranged from one-fourth to one-half inch long. Additionally, there were several hairs on the right side of R3's chin which were roughly one inch long. R3 explained the nursing assistants do not always provide her grooming assistance and seem rushed for time. R3 stated she needed assistance to complete her bathing and nail care adding she was supposed to have a bath every Monday. Further, R3 stated she liked having her nails long but added, "I need them filed, cleaned, and painted." During an interview on 1/13/22, at 11:30 a.m., NA-A stated she was responsible for the care for R3 and expressed she was aware of the facial hair on R3's upper lip and chin in addition to R3's finger nails being long and dirty underneath. NA-A	F 677		

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	245264	A. BUILDING _____ B. WING _____	C 01/13/2022

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F 677	Continued From page 11	F 677		

stated she had not cleaned R3 up yet today and R3 required her assistance for her ADLs, however, acknowledged R3 should be provided grooming.

During an interview with registered nurse (RN)-D on 1/13/22, at 11:52 a.m., RN-D stated the nursing assistants should provide grooming cares for the resident per the resident's care plan. RN-D stated she was not aware of R3 facial hair or long dirty finger nails.

During an interview with R3's family member (FM)-B on 1/13/22, at 1:20 p.m., they expressed R3 had complained of the facial hair on her chin and upper lip, and the dirty finger nails. FM-B stated her mom does enjoy having her nails long and painted but does not like the dirt under neath them. FM-B stated her mom took pride in her looks and does not like her not having her basic grooming needs met.

During an interview on 1/13/22, at 1:46 p.m. the director of nursing (DON) stated staff should provide the ADL care as directed per the resident's care plan which includes shaving of the chin and upper lip, and nail care. Further, DON stated staff should provide nail care on shower days or at least offer it.

The facility's policy Nursing Assistant Standard Cares, dated 12/13/18, indicated nursing staff will provide quality care. The facility's policy directed staff to provide nail care weekly and as needed and to keep nails clean. The policy further directed staff to provide daily facial hair grooming for females as needed.

Electronically delivered
January 25, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: 93U911

Dear Administrator:

The above facility was surveyed on January 12, 2022 through January 13, 2022 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:

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 01/13/2022

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AUGUSTANA HCC OF APPLE VALLEY	**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 1/12/22 to 1/13/22, a survey was conducted by surveyors from the Minnesota Department of Health (MDH) to determine compliance for state licensure in conjunction with complaint investigation(s): H5264161C (MN79751) and H5264162C (MN80026)	2 000		

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2 000	Continued From page 1 As a result, the following correction orders are issued. Please indicate your electronic plan of correction that you have reviewed these order, and identify the date when they will be corrected. 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 surveyors 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm 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 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,	2 000		

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2 000	Continued From page 2 "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.	2 000		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure assistance was provided with routine grooming and personal hygiene for 1 of 3 residents (R3) reviewed for activities of daily living (ADLs) and who was dependent on staff for care.	2 915		

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2 915	Continued From page 3 Findings include: R3's annual Minimum Data Set (MDS), dated 12/29/21, indicated R3 was cognitively intact and demonstrated no behavior(s). Further, the MDS identified R3 required extensive assistance for their bed mobility and personal hygiene. R3's care plan dated 1/1/22, indicated R3 had a problem with ADL function and required assistance with grooming related to dementia and weakness. R3's care plan directed staff to assist resident with grooming. On 1/13/22, at 11:16 a.m. R3 was observed laying in bed. R3 had visibly long nails present on both hands and several nails had a visible tan/brown colored substance underneath. Multiple nails were curled underneath on the side. In addition, R3's hair appeared uncombed with and appeared greasy. Further, R3 had visible black-colored facial hair present on her upper lip and chin which ranged from one-fourth to one-half inch long. Additionally, there were several hairs on the right side of R3's chin which were roughly one inch long. R3 explained the nursing assistants do not always provide her grooming assistance and seem rushed for time. R3 stated she needed assistance to complete her bathing and nail care adding she was supposed to have a bath every Monday. Further, R3 stated she liked having her nails long but added, "I need them filed, cleaned, and painted." During an interview on 1/13/22, at 11:30 a.m., NA-A stated she was responsible for the care for R3 and expressed she was aware of the facial hair on R3's upper lip and chin in addition to R3's finger nails being long and dirty underneath. NA-A stated she had not cleaned R3 up yet today and	2 915		

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2 915	Continued From page 4 R3 required her assistance for her ADLs, however, acknowledged R3 should be provided grooming. During an interview with registered nurse (RN)-D on 1/13/22, at 11:52 a.m., RN-D stated the nursing assistants should provide grooming cares for the resident per the resident's care plan. RN-D stated she was not aware of R3 facial hair or long dirty finger nails. During an interview with R3's family member (FM)-B on 1/13/22, at 1:20 p.m., they expressed R3 had complained of the facial hair on her chin and upper lip, and the dirty finger nails. FM-B stated her mom does enjoy having her nails long and painted but does not like the dirt under neath them. FM-B stated her mom took pride in her looks and does not like her not having her basic grooming needs met. During an interview on 1/13/22, at 1:46 p.m. the director of nursing (DON) stated staff should provide the ADL care as directed per the resident's care plan which includes shaving of the chin and upper lip, and nail care. Further, DON stated staff should provide nail care on shower days or at least offer it. The facility's policy Nursing Assistant Standard Cares, dated 12/13/18, indicated nursing staff will provide quality care. The facility's policy directed staff to provide nail care weekly and as needed and to keep nails clean. The policy further directed staff to provide daily facial hair grooming for females as needed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable polices and procedures	2 915		

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2 915	Continued From page 5 pertaining to the timely completion of resident activities of daily living (ADLs); then inservice direct care staff on such procedures and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written	21880		

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21880	Continued From page 6 grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a voiced grievance concerning call light response times was addressed and resolved to satisfaction for 1 of 1 resident (R1) who reported increased pain due to waiting extended periods for call light response. Findings include: R1's admission Minimum Data Set (MDS), dated 10/25/21, identified R1 had moderate cognitive impairment and required extensive assistance of one staff with most of his activities of daily living (ADLs). Further, the MDS outlined R2 received both scheduled and as needed (PRN) medication for pain relief. R1 voiced pain almost constantly described as "severe," limited day to day activities, and made it hard to for R1 to sleep at night. During an interview with R1 on 1/12/22, at 12:00 p.m. R1 stated he had reported multiple times to registered nurse (RN)-A and to social worker	21880		

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21880	Continued From page 7 (SW)-A concerns regarding long call light wait times. Review of the facility's December 2021 and January 2022 Grievance Logs lacked indication of R1's expressed concern. During an interview on 1/12/22, at 1:11 p.m. SW-A confirmed she met with R1 who had voiced concerns regarding long wait times During December and January. SW-A stated R1 had verbalized he was using the call light due to severe pain and needing medications. SW-A confirmed she did not file a grievance regarding R1's concern for long call light times. When interviewed on 1/13/22, at 12:58 p.m. the social service director (SSD) stated it is the responsibility of staff to report concerns even if R1 requested to remain anonymous to ensure his grievance. SSD expressed SW-A should had completed a grievance form when R1 complained of long call light response times so it could be routed to the correct person to be addressed. SSD stated her expectation would include all social workers informing the residents of their right to file a grievance upon admission, assist residents with writing grievances, and complete a grievance form for each grievance. The facility's Vulnerable Adult policy, dated 11/21/18, indicated all staff should treat each resident with respect and dignity, and staff were to provide required goods and services to residents which were necessary to avoid pain. Further, the policy indicated the facility would provide information to the resident and family with how to file a grievance. SUGGESTED METHOD OF CORRECTION:	21880		

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21880	Continued From page 8 The social services director (SSD) and/or their designee could develop/revise policies for resident and family grievances and educate all facility staff on those policies. The SSD and/or designee could conduct resident and family interviews to ensure resident grievances are being fulfilled. They could monitor these on a routine basis to ensure grievances were acted upon. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		