Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 4, 2024

Administrator
Providence Place
3720 23rd Avenue South
Minneapolis, MN 55407

RE: CCN: 245271
Cycle Start Date: October 1, 2024

Dear Administrator:

On October 30, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 4, 2024

Administrator
Providence Place
3720 23rd Avenue South
Minneapolis, MN 55407

Re: Reinspection Results
Event ID: VTKV12

Dear Administrator:

On October 30, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 1, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 14, 2024

Administrator
Providence Place
3720 23rd Avenue South
Minneapolis, MN 55407

RE: CCN: 245271
Cycle Start Date: October 1, 2024

Dear Administrator:

On October 1, 2024, a 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.

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:

Nicole Osterlohl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102 Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 January 1, 2025 (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 April 1, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the

Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 14, 2024

Administrator
Providence Place
3720 23rd Avenue South
Minneapolis, MN 55407

Re: State Nursing Home Licensing Orders
Event ID: VTKV11

Dear Administrator:

The above facility was surveyed on September 27, 2024 through October 1, 2024 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:

Nicole Osterlohl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102 Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 9/27/24, 9/30/24, and 10/1/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed during the survey: H52718011C (MN106486) and H52718841C (MN106933 and MN106943) with deficiencies issued at F600 and F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		10/25/24

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

Electronically Signed | 10/15/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600	Continued From page 1 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure staff had not taken unauthorized pictures without consent for 1 of 4 residents (R4) reviewed for abuse. This had the potential for mental abuse using a reasonable person concept. Findings include: R4's quarterly Minimal Data Set (MDS) dated 8/9/24, indicated R4's diagnoses included paranoid schizophrenia, schizoaffective disorder bipolar type, and R4 had moderately impaired cognition. R4's Vulnerable Adult Evaluation dated 6/26/24, identified R4 had physical limitations which made him susceptible to abuse due to R4 required assistance with cares and activities of daily living (ADLs). Further, R4 was identified to have cognitive deficits which made R4 susceptible to abuse due to changes in cognition related to diagnoses of paranoid schizophrenia and unspecified symptoms and signs involving cognitive functions and awareness. R4's care plan dated 6/21/24, indicated R4 had a diagnosis of schizoaffective disorder bipolar type with paranoia and R4 had a history of refusing cares, showers, changing clothes, and meals. R4 had a history of making statements like "Maybe I should just kill myself" and "Maybe I should just	F 600	F600 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. Aegis Therapies has removed COTA-A from practicing at Providence Place. Police were notified regarding the incident. R4’s Guardian was updated about the photographs during OHFC visit. Guardian of R4 requested that resident not be told about the incident. R4 has had no negative outcome. Care plan updated to reflect monitoring for any negative affects from photograph. Facility reviewed cell phone images, and no other residents were noted to have been in observed photographs.	

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F 600	Continued From page 2 go to heaven" when he was feeling frustrated but denied having a plan to hurt himself. Further, R4's care plan identified R4 had an ADL self-care performance deficit exhibited by R4 refusing to change clothes and be assisted with routine hygiene and would refuse to allow staff to wash his jacket, or clothing until he decided that they were dirty enough to clean, refused to allow wheelchair to be washed, wears long and unshaven facial hair, and did not change socks. R4 had a history of the following behaviors: refused to change clothing despite being dirty/soiled, refuse to be toileted, transferred, changed. Often found sleeping in wheelchair and would become angry if staff encouraged to go to room to lay down, R4 was often observed leaning over side of wheelchair sleeping and refuse to lay down and would become verbally and physically abusive with attempt to move him or assist him to lay down. Review of email sent by the ED on 9/30/24 at 5:32 p.m., revealed there was a text message conversation sent from COTA-A which contained a behind view of R4, who was wearing a blue top, sitting in his wheelchair, and leaning over to the right side. This text message had a date of 9/9/24, and the picture did not reveal R4's face. The text message sent by COTA-A to R1. There was no context to the picture. During an interview on 10/1/24 at 11:20 a.m., ED stated COTA-A was a contracted therapy staff and they were aware of the two pictures, who he identified as R4, on 9/24/24. ED stated R4 was "mentally ill", resistive to cares, and would stay up late and sleep odd hours in his wheelchair in the hallway. ED indicated COTA-a was a contracted therapy staff and R4 was not receiving therapy	F 600	2. Providence Place reviewed cell phone messages and photos taken within those messages. Facility reviewed Grievances for past 6 months to ensure no concerns were noted regarding unauthorized photos being taken or concerns regarding photography. 3. Facility guidelines regarding cell phone use and photography were reviewed and remain up to date. VA policy was reviewed and is up to date. Audits were completed with Providence Place employees to ensure education on VA policy and Cell phone/photography were completed. Contracted staff employee files were audited for VA policy and Cell phone/photography policy and were found out of compliance with the training on Cell phone/photograph policy. Contracted staff orientation practice has been adjusted to include the education on Cell phone use/photographs. VA training continues. 4. All contracted company employees will receive retraining on the facilities VA policy. All contracted employees will receive training on Providence Place's guidelines for cell phone use and photography. All facility employees will receive training on Providence Place's guidelines for cell phone use and photography. All newly hired contracted staff will have the facility's guidelines for cell phone use	

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F 600	Continued From page 3 services, so ED was not sure why COTA-A would have taken a picture of R4 other than passing by him in the hallway. Further, ED stated R4 appeared to be sleeping in the two pictures COTA-A took. ED stated after seeing the pictures of R4 he was "frustrated" and confirmed he did not ask COTA-A why she took the picture. On 10/1/24 at 12:09 p.m., assistant executive director (AED) stated he was aware of the pictures of R4 sent by COTA-A, and stated it was "inappropriate" as it violated the facility policy. Further, the AED stated R4 would not be "happy" unauthorized pictures were sent of him. On 10/1/24 at 12:15 p.m., guardian (G)-A stated R4 had impaired cognition and if he was upset, he would "let staff know". G-A stated she was not aware unauthorized pictures were sent of R4, and stated R4 would be "pissed off" and "angry" if he knew. G-A asked surveyor not to speak with R4 about the incident as R4 would then become "paranoid and fixated on it" as that was part of his diagnoses. Interview with COTA-A was unsuccessful. Review of facility policy titled Personal Phones, Communication Devices, and Cameras in the Workplace revised 7/1/24, indicated any use of a cell phone or other communication device must not be in the presence of a resident or client and personal cameras or devices with photo capability must never be used on facility premises to take pictures without prior approval and are limited to that specific use approved. Review of facility policy titled Vulnerable Adult/Maltreatment-Communication, Prevention,	F 600	and photography added to their general orientation. VA training for contracted employees will remain as part of their orientation process. ED or designee will complete monthly audits on all contracted newly hired staff weekly x1 month and then monthly x1 month to ensure orientation was completed and both the VA policy and the facilities cell phone/photography guidelines were reviewed. ED or designee will complete weekly audits x1 month to ensure staff are not using cell phone in a way that violates facility cellphone policy. ED or designee will bring results of audits to QAPI monthly for review 5. POC date of correction: October 25th, 2024	

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F 600	Continued From page 4 and Reporting revised 10/22, indicated all adult residents living or receiving services in the facility are vulnerable and come under the protection of the Vulnerable Adult Act (VAA) and it's the policy to ensure the resident was free from abuse, neglect, mistreatment. Further, the policy an occupational therapist as a licensed health professional. The facility policy also defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. It would include verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Mental abuse included but was not limited to humiliation, harassment, and threats of punishment or deprivation. Technology abuse was defined as unauthorized photographs or videos of a resident.	F 600		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all	F 610		10/25/24

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F 610	Continued From page 5 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate an allegation of staff to resident abuse for 2 of 4 residents (R1 and R4) reviewed involving 1 of 1 contracted staff (certified occupational therapy assistant (COTA)-A)). Findings include: R1's quarterly Minimal Data Set (MDS) dated 8/13/24, indicated R1's diagnoses included anxiety disorder, major depressive disorder, paranoid personality disorder and R1 was cognitively intact. R4's quarterly MDS dated 8/9/24, indicated R4's diagnoses included paranoid schizophrenia, schizoaffective disorder bipolar type, and R4 had moderately impaired cognition. Review of facility report to the State Agency dated 9/24/24, indicated R1 who was no longer a resident at the facility, reported consensual sexual relations and a consensual relationship with COTA-A. On 10/1/24 at 11:20 a.m., executive director (ED) stated as part of the investigation for R1's allegation, two therapy staff were interviewed; however no facility floor staff were interviewed regarding R1 and COTA-A. ED stated while	F 610	F610 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1.R1 has been discharged from the facility. R4 remains at the facility and Guardian has requested he not be informed of the incident. COTA-A has been removed from her position at Providence Place 2.No additional photos of other Providence Place residents or allegations were found within the text messages noted during the investigation. Grievances were reviewed and no other similar incidents have ben reported. 3. Facilities standard of practice/process for investigations of alleged abuse/neglect were reviewed.	

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F 610	Continued From page 6 investigating R1's allegation, ED discovered text messages from COTA-A to R1 which contained two pictures of R4. Further, ED stated the pictures of R4 sent by COTA were not addressed, and ED stated the therapy department was trained related to abuse "which wouldn't cover the electronic piece, we haven't done anything directly with that". On 10/1/24 at 12:09 p.m., assistant executive director (AED) stated facility staff were not interviewed regarding R1 and COTA as it did not seem essential to the interview since R1 was fixated on the laundry room and there were no staff down in the laundry room at the time of the allegation and it would not be abnormal for therapy staff to assist a resident off the unit. Further, AED also confirmed the pictures of R4 on COTA-A's phone were not investigated or addressed. Review of facility policy titled Vulnerable Adult/Maltreatment-Communication, Prevention, and Reporting revised on 10/22, indicated employees would report findings, verbally and immediately to their supervisor, the supervisor would then immediately report to the administrator and director of nursing. The administrator or designee would initiate an investigation and any findings would be acted upon immediately by the administrator. The policy lacked staff direction on what was expected to be included as part of the investigation.	F 610	4.All facility Department Heads will receive re-training on the investigatory process, the information and documentation required as well as staff and resident interviews. ED and DNS will review all investigation notes and interviews to ensure process has been completed in its entirety. ED or designee will complete weekly audits x1 month then monthly audits x 1 month on all investigations to ensure reports and investigation notes are complete and thorough. ED or designee will bring results of audits to QAPI monthly for review. 5.POC date of correction: October 25th, 2024	

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	00096	A. BUILDING: _____ B. WING _____	10/01/2024

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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 9/27/24, 9/30/24, and 10/1/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure The following complaints were reviewed during	2 000		

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2 000	Continued From page 1 the survey: H52718011C (MN106486) and H52718841C (MN106933 and MN106943) with a licensing order issued at 1850. 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 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.	2 000		

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2 000	Continued From page 2 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		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interviews and record review, the facility failed to ensure staff had not taken unauthorized pictures without consent for 1 of 4 residents (R4) reviewed for abuse. This had the potential for mental abuse using a reasonable person concept. Findings include:	21850	Corrected	10/25/24

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21850	Continued From page 3 R4's quarterly Minimal Data Set (MDS) dated 8/9/24, indicated R4's diagnoses included paranoid schizophrenia, schizoaffective disorder bipolar type, and R4 had moderately impaired cognition. R4's Vulnerable Adult Evaluation dated 6/26/24, identified R4 had physical limitations which made him susceptible to abuse due to R4 required assistance with cares and activities of daily living (ADLs). Further, R4 was identified to have cognitive deficits which made R4 susceptible to abuse due to changes in cognition related to diagnoses of paranoid schizophrenia and unspecified symptoms and signs involving cognitive functions and awareness. R4's care plan dated 6/21/24, indicated R4 had a diagnosis of schizoaffective disorder bipolar type with paranoia and R4 had a history of refusing cares, showers, changing clothes, and meals. R4 had a history of making statements like "Maybe I should just kill myself" and "Maybe I should just go to heaven" when he was feeling frustrated but denied having a plan to hurt himself. Further, R4's care plan identified R4 had an ADL self-care performance deficit exhibited by R4 refusing to change clothes and be assisted with routine hygiene and would refuse to allow staff to wash his jacket, or clothing until he decided that they were dirty enough to clean, refused to allow wheelchair to be washed, wears long and unshaven facial hair, and did not change socks. R4 had a history of the following behaviors: refused to change clothing despite being dirty/soiled, refuse to be toileted, transferred, changed. Often found sleeping in wheelchair and would become angry if staff encouraged to go to room to lay down, R4 was often observed leaning over side of wheelchair sleeping and refuse to lay	21850		

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21850	Continued From page 4 down and would become verbally and physically abusive with attempt to move him or assist him to lay down. Review of email sent by the ED on 9/30/24 at 5:32 p.m., revealed there was a text message conversation sent from COTA-A which contained a behind view of R4, who was wearing a blue top, sitting in his wheelchair, and leaning over to the right side. This text message had a date of 9/9/24, and the picture did not reveal R4's face. The text message sent by COTA-A to R1. There was no context to the picture. During an interview on 10/1/24 at 11:20 a.m., ED stated COTA-A was a contracted therapy staff and they were aware of the two pictures, who he identified as R4, on 9/24/24. ED stated R4 was "mentally ill", resistive to cares, and would stay up late and sleep odd hours in his wheelchair in the hallway. ED indicated COTA-a was a contracted therapy staff and R4 was not receiving therapy services, so ED was not sure why COTA-A would have taken a picture of R4 other than passing by him in the hallway. Further, ED stated R4 appeared to be sleeping in the two pictures COTA-A took. ED stated after seeing the pictures of R4 he was "frustrated" and confirmed he did not ask COTA-A why she took the picture. On 10/1/24 at 12:09 p.m., assistant executive director (AED) stated he was aware of the pictures of R4 sent by COTA-A, and stated it was "inappropriate" as it violated the facility policy. Further, the AED stated R4 would not be "happy" unauthorized pictures were sent of him. On 10/1/24 at 12:15 p.m., guardian (G)-A stated R4 had impaired cognition and if he was upset, he would "let staff know". G-A stated she was not	21850		

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21850	Continued From page 5 aware unauthorized pictures were sent of R4, and stated R4 would be "pissed off" and "angry" if he knew. G-A asked surveyor not to speak with R4 about the incident as R4 would then become "paranoid and fixated on it" as that was part of his diagnoses. Interview with COTA-A was unsuccessful. Review of facility policy titled Personal Phones, Communication Devices, and Cameras in the Workplace revised 7/1/24, indicated any use of a cell phone or other communication device must not be in the presence of a resident or client and personal cameras or devices with photo capability must never be used on facility premises to take pictures without prior approval and are limited to that specific use approved. Review of facility policy titled Vulnerable Adult/Maltreatment-Communication, Prevention, and Reporting revised 10/22, indicated all adult residents living or receiving services in the facility are vulnerable and come under the protection of the Vulnerable Adult Act (VAA) and it's the policy to ensure the resident was free from abuse, neglect, mistreatment. Further, the policy an occupational therapist as a licensed health professional. The facility policy also defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. It would include verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Mental abuse included but was not limited to	21850		

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21850	Continued From page 6 humiliation, harassment, and threats of punishment or deprivation. Technology abuse was defined as unauthorized photographs or videos of a resident. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise policies or procedures to ensure appropriate interventions and oversight is provided to prevent further abuse or neglect from occuring. The facility could audit all complaints of abuse or neglect to ensure appropriate assessments, interventions, and monitoring occur to prevent further abuse or neglect and educate all staff on those policies. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: 21 DAYS	21850		