Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 15, 2023

Administrator
The Waterview Woods LLC
601 Grant Avenue
Eveleth, MN 55734

RE: CCN: 245277
Cycle Start Date: August 25, 2023

Dear Administrator:

On September 21, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 15, 2023

Administrator
The Waterview Woods LLC
601 Grant Avenue
Eveleth, MN 55734

Re: Reinspection Results
Event ID: 5VS512

Dear Administrator:

On September 21, 2023 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 August 25, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 8, 2023

Administrator
The Waterview Woods LLC
601 Grant Avenue
Eveleth, MN 55734

RE: CCN: 245277
Cycle Start Date: August 25, 2023

Dear Administrator:

On August 25, 2023, 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by November 25, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 25, 2024 (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
Health Regulation Division
Telephone: (651) 201-4112
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
	245277	A. BUILDING ______ B. WING ______	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERVIEW WOODS LLC	601 GRANT AVENUE EVELETH, MN 55734

(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 8/24/23 through 8/25/23, 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. H52774653C (MN96020) H52774911C (MN92608) H52774912C (MN92483) Deficient practice was identified related to incidental finding with deficiencies cited at F609, F610 and F689. Use this statement if deficiencies are issued on this survey 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		9/18/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/12/2023

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 609	Continued From page 1 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to report an allegation of resident to resident sexual abuse to the state agency (SA) for 1 of 1 residents (R1) who alleged sexual abuse. Findings include: R1's quarterly Minimum Data Set identified intact cognition and indicated no hallucinations, delusions or behaviors. R1's care plan dated 3/29/23, indicated she was a vulnerable adult	F 609	F609 Reporting of Alleged Violation Immediate Corrective Action: Facility DON and Administrator received education on need to make a report to state agency for any allegations of resident abuse. Corrective Action as it applies to others: The MN Abuse Prevention policy was reviewed and remains current. All grievances and incidents from last 2	

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F 609	Continued From page 2	F 609		

while she resided in a skilled nursing facility. The care plan directed staff to be aware of statements or signs/symptoms of abuse and indicated staff would continue to follow the facility vulnerable adult & abuse reporting policy.

During interview on 8/24/23, at 3:40 p.m. R1 stated R4 had touched her inappropriately but the behavior had stopped. R1 said she no longer goes near R4. R1 stated R4 had been rubbing her shoulder and he had gone further down and touched her breast and said she had reported it to facility staff.

During an interview on 8/25/23, at 11:52 a.m. The director of nursing (DON) confirmed the allegation had not been reported to the SA. The DON stated she had been on vacation at the time and the administrator would have been responsible to file the report. The DON said a report should have been made within two hours of learning about the incident.

Facility policy Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating dated April 2021, indicated if resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to the state licensing/certification agency responsible for surveying/licensing the facility. The policy defined immediately as within two hours of an allegation involving abuse or result in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.

weeks will be reviewed to ensure that incident was not reportable to state agency.
DON and Administrator were educated on need to make a report to state agency for any allegations of abuse within 2 hours.

Date of Compliance:
9/18/23

Recurrence will be prevented by:
All incidents and grievances from last week will be reviewed to ensure that incident was reported if an allegation of abuse occurred. This will occur weekly x4 weeks then monthly times 2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit.

Corrections will be monitored by:
Administrator or Designee

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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 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to thoroughly investigate an allegation of resident to resident sexual abuse for 1 of 1 residents (R1) who alleged sexual abuse in the facility. Findings include: R1's quarterly Minimum Data Set (MDS) identified intact cognition and indicated no hallucinations, delusions or behaviors. R1's care plan dated 3/29/23, indicated she was a vulnerable adult while she resided in a skilled nursing facility. The care plan directed staff to be aware of statements or signs/symptoms of abuse and indicated staff would continue to follow the facility vulnerable adult & abuse reporting policy.	F 610	F610 Investigate/Prevent Alleged Violation Immediate Corrective Action: Facility DON and Administrator received education on need to thoroughly investigate all incidents to determine if there were allegations of abuse that needs to be reported to state agency within 2 hours. Corrective Action as it applies to others: The MN Abuse Prevention policy was reviewed and remains current. All grievances and incidents from last 2 weeks will be reviewed to ensure that a through investigation occurred and that	9/18/23

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F 610

Continued From page 4

During interview on 8/24/23, at 3:40 p.m. R1 stated R4 had touched her inappropriately but the behavior had stopped. R1 said she no longer goes near R4. R1 stated R4 had been rubbing her shoulder and he had gone further down and touched her breast and said she had reported it to facility staff. When asked about her initial report to the facility, R1 stated she felt she was clear when she reported she was touched on the breast by the other resident, not just touched on the shoulder.

R1's facility Progress Note dated 7/12/23, indicated staff member and R1 had a 1:1 in office, R1 started to talk and immediately started to cry. R1 had anger and rage aimed at another resident. The note indicated the situation was currently being addressed by other staff and writer was working with R1 trying to comfort her. Currently staff was working hard to get a resolution as quickly as possible. A second noted dated 7/12/23, indicated R1 was upset that another resident had touched her arm. Writer asked R1 to demonstrate where her arm was touched. R1 stated, "it was right below my right shoulder," and demonstrated where it happened. R1 stated she was uncomfortable due to past traumas. Care plan was updated.

R4's annual MDS dated 6/19/23, identified intact cognition. R4's care plan dated 6/19/23, identified him as a vulnerable adult due to residing in a long term care facility.

R4's facility Progress Note dated 7/10/23 (two days earlier than R1's progress note about initial report), indicated writer talked to resident with the Administrator and nurse managers present

F 610

the incident was reported per Abuse Policy guidelines as appropriate.
Facility DON and Administrator received education on the need to thoroughly investigate all incidents to determine if there were allegations of abuse that needs to be reported to state agency within 2 hours.

Date of Compliance:
9/18/23

Recurrence will be prevented by:
All incidents and grievances from last week will be reviewed to ensure that a thorough investigation occurred, and that the incident was reported per Abuse Policy guidelines as appropriate. This will occur weekly x4 weeks then monthly times 2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit.

Corrections will be monitored by:
Administrator or Designee

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F 610	Continued From page 5	F 610		

about boundaries being set.

During interview on 8/25/23, at 9:54 a.m. the director of nursing (DON) stated the administrator had investigated the alleged incident between R1 and R4. The DON stated R4 had touched R1 on the shoulder from behind so his hand had come over her shoulder. The DON said R4 had just "grazed" R1's shoulder. The DON stated R1 and R4 were asked to steer clear of each other.

An untitled, undated document identified as the facility investigation by the interim administrator indicated the following: Writer spoke to R1 regarding an encounter with another resident touching her arm. Writer asked R1 to demonstrate where her arm was touched, R1 stated, "it was right below my right shoulder," and demonstrated where it happened. R1 stated, "The encounter triggered what has happened in the past to me." Resident was adamant to know what was being done and when the other resident could be kicked out of the facility. Writer stated she could not discuss details of what is being done with another resident and asked how we could help make her feel better about the situation. R1 stated she would like the authorities called, the SA, and for the other resident to be kicked out by tomorrow. After a few minutes, R1 stated, "it was like he wanted to touch my breast." Writer did ask again where he touched her arm, and she demonstrated right below her right shoulder. R4 was interviewed and stated he was just trying to get her attention to say hello and acknowledge her. He stated he had no intention of touching her inappropriately. The investigation lacked evidence of interviews with staff or other residents even though R4 indicated there were two witnesses to the alleged incident.

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F 610	Continued From page 6 Facility policy Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating dated April 2021, indicated All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. The individual conducting the investigation as a minimum: reviews the documentation and evidence; reviews the resident ' s medical record to determine the resident ' s physical and cognitive status at the time of the incident and since the incident; observes the alleged victim, including his or her interactions with staff and other residents; interviews the person(s) reporting the incident; interviews any witnesses to the incident; interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; reviews all events leading up to the alleged incident; and documents the investigation completely and thoroughly.	F 610		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 689	F689 Free of Accidents/Hazards	9/18/23

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F 689	Continued From page 7 review the facility failed to implement interventions to prevent further injury for 1 of 3 residents (R5) reviewed for smoking who burned his foot while smoking a cigarette. Findings include: R5's quarterly Minimum Data Set dated 7/7/23, identified intact cognition and indicated he required supervision for locomotion on and off the unit and had no functional limitation of his upper or lower extremities. R5's care plan dated 8/16/23, indicated he currently smoked at the facility and was able to independently and safely smoke at the facility per his assessment. R5's Smoking Evaluation dated 8/23/23, indicated R5 was able to light, smoke and extinguish cigarette appropriately. "Is independent with smoking at this time." The evaluation lacked interventions to prevent further injury while smoking. R1's Incident Review and Analysis dated 8/25/23, indicated on 8/23/23, during R5's shower staff noted a burn to the top of his right foot. Nurse assessed area; centimeter (cm) x 1 cm burn to foot. R5 stated that he unknowingly dropped the cherry of his cigarette on to the top of his foot a couple of days ago and did not report it to anyone. R5 wore gripper socks for footwear. Smoking assessment completed and R5 remained safe to smoke independently. R5 did not have a history of burning himself with a cigarette and this was likely an isolated incident. Contributing factors indicated R5 stated that he was not near an ashtray, so he was flicking his cherry and it landed on his foot.	F 689	Immediate Corrective Action: Resident #5's smoking assessment was completed again and appropriate interventions were care planned. Corrective Action as it applies to others: The Resident Smoking Policy was reviewed and remains current. All residents who smoke were reassessed for safe smoking and care plans updated as appropriate with interventions. Clinical leadership that complete resident smoking assessments were re-educated on need to complete a new smoking assessment with any new concerns with resident smoking and to update care plan if needed with any changes. Date of Compliance: 9/18/23 Recurrence will be prevented by: Audits of all residents who smoke will be completed to ensure that current safety interventions are in place and that residents have been reassessed for smoking safety with any changes in condition. This will occur weekly x4 weeks then monthly times 2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: DON or Designee	

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F 689	Continued From page 8	F 689		

During observation on 8/25/23, at 9:09 a.m., the smoking patio was observed. The door leading to the patio had hours posted but did not identify how many residents could be on the patio at one time. On a bench leading to the outside were several smoking aprons available for use.

During interview on 8/25/23, at 9:16 a.m., R5 stated he wasn't close enough to an ashtray and was trying to flick his "cherry" off and it hit his foot. R5 stated he was wearing gripper socks at the time of the incident. R5 stated the facility staff had not offered any interventions such as shoes or a smoking apron for protection.

During interview on 8/26/23, at 9:46 a.m., the director of nursing (DON) stated R5 had flicked the cherry off his cigarette and it landed on his foot causing a burn. The DON stated R5 did not think it was a big deal and said a smoking assessment had been completed and he was still appropriate to smoke. When asked about interventions the DON stated they could offer shoes or a smoking apron but acknowledged the facility had not offered any interventions. The DON stated interventions should have been attempted.

Facility Resident Smoking Policy dated 10/2022, indicated the intent of the policy is to outline the procedure for safe resident smoking including evaluation of residents to determine those who are capable of smoking independently, and to provide a designated smoking area for those residents who choose to smoke. Residents who choose to smoke will be evaluated upon admission, significant change in condition/cognition, or exhibited inability to follow safe smoking practices or quarterly. The facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245277	A. BUILDING ______ B. WING ______	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERVIEW WOODS LLC	601 GRANT AVENUE EVELETH, MN 55734

(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 689	Continued From page 9 must document in the care plan and/or progress notes other attempted interventions to manage and accommodate smoking needs before revoking smoking privileges.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 8, 2023

Administrator
The Waterview Woods LLC
601 Grant Avenue
Eveleth, MN 55734

Re: State Nursing Home Licensing Orders
Event ID: 5VS511

Dear Administrator:

The above facility was surveyed on August 24, 2023 through August 25, 2023 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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.

Sincerely,

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00583	A. BUILDING: ______ B. WING ______	08/25/2023

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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 8/24/23 through 8/25/23, 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, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed. H52774653C (MN96020) H52774911C (MN92608) H52774912C (MN92483) As a result of the survey licensing order was issued at 1980. 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	2 000		

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2 000	Continued From page 2 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		
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 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.	21980		9/18/23

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21980	Continued From page 3	21980		

(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 (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 thoroughly investigate an allegation of resident to resident sexual abuse for 1 of 1 residents (R1) who alleged sexual abuse in the facility.

Provider's Plan of Correction: Corrected

Findings include:

R1's quarterly Minimum Data Set (MDS) identified intact cognition and indicated no hallucinations, delusions or behaviors. R1's care plan dated 3/29/23, indicated she was a vulnerable adult

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21980	Continued From page 4	21980		

while she resided in a skilled nursing facility. The care plan directed staff to be aware of statements or signs/symptoms of abuse and indicated staff would continue to follow the facility vulnerable adult & abuse reporting policy.

During interview on 8/24/23, at 3:40 p.m. R1 stated R4 had touched her inappropriately but the behavior had stopped. R1 said she no longer goes near R4. R1 stated R4 had been rubbing her shoulder and he had gone further down and touched her breast and said she had reported it to facility staff. When asked about her initial report to the facility, R1 stated she felt she was clear when she reported she was touched on the breast by the other resident, not just touched on the shoulder.

R1's facility Progress Note dated 7/12/23, indicated staff member and R1 had a 1:1 in office, R1 started to talk and immediately started to cry. R1 had anger and rage aimed at another resident. The note indicated the situation was currently being addressed by other staff and writer was working with R1 trying to comfort her. Currently staff was working hard to get a resolution as quickly as possible. A second noted dated 7/12/23, indicated R1 was upset that another resident had touched her arm. Writer asked R1 to demonstrate where her arm was touched. R1 stated, "it was right below my right shoulder," and demonstrated where it happened. R1 stated she was uncomfortable due to past traumas. Care plan was updated.

R4's annual MDS dated 6/19/23, identified intact cognition. R4's care plan dated 6/19/23, identified him as a vulnerable adult due to residing in a long term care facility.

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21980	Continued From page 5	21980		

R4's facility Progress Note dated 7/10/23 (two days earlier than R1's progress note about initial report), indicated writer talked to resident with the Administrator and nurse managers present about boundaries being set.

During interview on 8/25/23, at 9:54 a.m. the director of nursing (DON) stated the administrator had investigated the alleged incident between R1 and R4. The DON stated R4 had touched R1 on the shoulder from behind so his hand had come over her shoulder. The DON said R4 had just "grazed" R1's shoulder. The DON stated R1 and R4 were asked to steer clear of each other.

An untitled, undated document identified as the facility investigation by the interim administrator indicated the following: Writer spoke to R1 regarding an encounter with another resident touching her arm. Writer asked R1 to demonstrate where her arm was touched, R1 stated, "it was right below my right shoulder," and demonstrated where it happened. R1 stated, "The encounter triggered what has happened in the past to me." Resident was adamant to know what was being done and when the other resident could be kicked out of the facility. Writer stated she could not discuss details of what is being done with another resident and asked how we could help make her feel better about the situation. R1 stated she would like the authorities called, the SA, and for the other resident to be kicked out by tomorrow. After a few minutes, R1 stated, "it was like he wanted to touch my breast." Writer did ask again where he touched her arm, and she demonstrated right below her right shoulder. R4 was interviewed and stated he was just trying to get her attention to say hello and acknowledge her. He stated he had no intention of touching her inappropriately. The investigation

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21980	Continued From page 6	21980		

lacked evidence of interviews with staff or other residents even though R4 indicated there were two witnesses to the alleged incident.

Facility policy Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating dated April 2021, indicated All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. The individual conducting the investigation as a minimum: reviews the documentation and evidence; reviews the resident ' s medical record to determine the resident ' s physical and cognitive status at the time of the incident and since the incident; observes the alleged victim, including his or her interactions with staff and other residents; interviews the person(s) reporting the incident; interviews any witnesses to the incident; interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; reviews all events leading up to the alleged incident; and documents the investigation completely and thoroughly.

SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility should re-educate staff to policies and procedures, and audit all complaints of alleged abuse or neglect. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance.

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21980	Continued From page 7 TIME PERIOD FOR CORRECTION: 21 DAYS	21980		