Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 1, 2023

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

RE: CCN: 245277
Cycle Start Date: February 2, 2023

Dear Administrator:

On March 1, 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.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 1, 2023

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

Re: Reinspection Results
Event ID: 2CJ612

Dear Administrator:

On March 1, 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 February 2, 2023. At this time these correction orders were found corrected.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 17, 2023

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

RE: CCN: 245277
Cycle Start Date: February 2, 2023

Dear Administrator:

On February 2, 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:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for 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 May 2, 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 August 2, 2023, (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.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement | Licensing and Certification
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-mail: Lori.Hagen@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 17, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: 2CJ611

Dear Administrator:

The above facility was surveyed on February 1, 2023, through February 2, 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:

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

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

Please feel free to contact me with any questions regarding this letter.

Lori Hagen, Compliance Analyst
Federal Enforcement | Licensing and Certification
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-mail: Lori.Hagen@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 02/02/2023

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 2/1/23, and 2/2/23, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to be NOT IN compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be UNSUBSTANTIATED: H52778054C (MN90174). The following complaint was found to be SUBSTANTIATED: H52777862C (MN90476), with deficiencies cited at F609, F656, F686. 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: §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	F 609		2/27/23

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

Electronically Signed | 02/21/2023

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 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 ensure allegations of rough treatment were reported to the State Agency (SA) for 1 of 3 residents (R1) reviewed for abuse. Findings include: R1's Diagnosis Report printed 2/7/23, indicated R1's diagnoses included heart disease, abnormal weight loss, dementia, disorientation, anxiety, falls and pain. R1's quarterly Minimum Data Set (MDS) dated 12/14/22, indicated R1 had severely impaired cognition and needed extensive assistance of two staff for activities of daily living (ADLs). A Minnesota Adult Abuse Reporting Center	F 609	F609 Reporting of Alleged Violations Immediate Corrective Action: Vulnerable adult report was filed by facility on 2/2/23. Corrective Action as it applies to others: The Abuse Prohibition Vulnerable Adult Policy was reviewed and remains current. All cognitively intact residents were interviewed to ensure that they don't have any concerns with staff that have not been addressed. All staff were educated on reporting allegations of abuse/mistreatment to DON/Administrator immediately.	

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F 609	Continued From page 2 (MAARC) report filed with the SA on 1/24/23, indicated R1 expressed to the reporter that he was in pain and sustained an injury to his shoulder when a nursing assistant (NA, name unknown) was being rough while changing R1's clothes on the overnight shift of 1/10/23. The NA slammed R1's shoulder against the bedrail. On 2/1/23, at 1:22 p.m. family member (FM)-B was interviewed and stated R1 told her and other family members that a female on the night shift was rough, and bumped his shoulder into the bedrail. On 2/1/23, at 3:24 p.m. registered nurse (RN)-A was interviewed. RN-A stated she had not received any reports regarding alleged abuse from R1, R1's family or from staff. RN-A was then informed R1 reported to his family members he was treated rough on the night shift of 1/10/23, when a nursing assistant slammed R1's shoulder against the bedrail which cause pain to R1's right shoulder. RN-A stated if she would have received any reports of rough treatment she would have reported it to the SA. On 2/2/23, at 10:12 a.m. FM-A was interviewed and stated he visited R1 often. FM-A stated he had last seen R1 the previous Sunday. FM-A stated during the visit, R1 talked about rough treatment from staff. R1 told FM-A a girl working the night shift banged him around, and hit his right shoulder on the bedrail while changing him. R1 told FM-A he was scared. Upon leaving, R1 stated to FM-A that if FM-A left, R1 would get beat up again. FM-A stated he reported the rough treatment to registered nurse (RN)-A and to other unknown staff.	F 609	Date of Compliance: 2/27/23 Recurrence will be prevented by: 5 cognitively intact residents will be interviewed to ensure that they don't have any concerns with staff. 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: Director of Nursing or Designee	

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F 609	Continued From page 3 On 2/2/23, at 10:45 a.m. the director of nursing (DON) was interviewed. The DON stated she had not received any reports of rough treatment of R1. The DON was informed the surveyor had reported R1's concerns of rough treatment to RN-A on 2/1/23, at 3:24 p.m. The DON stated she had heard from RN-A that morning there was a concern with R1 with rough cares or unhappy with the cares. The DON stated if rough treatment of a resident was reported to her, she would have done a grievance and done interviews with staff. The DON stated the alleged staff would have been pulled off the schedule pending the investigation, and the incident would reported if necessary. The facility's Abuse Prohibition/Vulnerable Adult policy dated 4/11/22, indicated directed suspicion of neglect, exploitation, or misappropriation of resident property must be reported to the SA not later than 2 hours if the incident resulted in serious bodily injury. If the suspected neglect, exploitation, or misappropriation of resident property did not result in serious bodily injury, the report must be made within 24 hours.	F 609		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		2/27/23

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F 656	Continued From page 4 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement care plan interventions for refusal of	F 656	F656 Develop/Implement Comprehensive Care Plan	

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 656	Continued From page 5 cares for 1 of 3 residents (R1), whose care plans were reviewed. Findings include: R1's Diagnosis Report printed 2/7/23, indicated R1's diagnoses included heart disease, abnormal weight loss, dementia, disorientation, anxiety, falls and pain. R1's quarterly Minimum Data Set (MDS) dated 12/14/22, indicated R1 had severely impaired cognition, and needed extensive assistance of two staff for activities of daily living (ADLs). R1's care plan dated 10/13/22, indicated R1 had a self care deficit related to falls with weakness. Interventions included: assistance of one staff with dressing, personal hygiene and bathing. R1 had an alteration in mood and behavior related to adjustment to the facility, a change in health condition, confusion, anxiety, disorientation, signs and symptoms involving cognitive functions and awareness and cerebral vascular accident (stroke). The care plan lacked interventions for when R1 refused to change his shirt due to right shoulder pain. A Minnesota Adult Abuse Reporting Center (MAARC) report filed with the State Agency SA on 1/24/23, indicated the reporter visited R1 a number of times since 10/22, and noticed R1 had not had his clothing changed for four to five days at a time. Progress notes from 10/10/22, through 1/10/23, indicated the following: On 10/10/22, R1 had an impairment in the left upper arm.	F 656	Immediate Corrective Action: Resident 1 assisted with changing clothing. Corrective Action as it applies to others: Care Planning Policy was reviewed and remains current. All residents were reviewed to determine those that consistently refuse care. Those identified residents will be further assessed on reasons why they are refusing cares and an individualized plan of care will be developed on resident preferences to help decrease the refusals. All nurses/TMAs/CNAs were educated on need to follow care plan/care sheets for resident preferences for cares to reduce resident refusals. Also, received education that any refusal of care needs to be documented and the reasons why to better identify concerns and develop future changes to care plan as appropriate. Date of Compliance: 2/27/23 Recurrence will be prevented by: 5 residents that are care planned that consistently refuse cares will be audited to ensure that their preferences were followed per care plan for ADLs and that resident refusals are documented including reasons for refusal. This will occur weekly x4 weeks then monthly times 2 months. This results of the audits will be shared with the facility QAPI	

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F 656	Continued From page 6 On 1/9/23, indicated R1 complained of left shoulder pain, and R1 had previously received cortisone injections which had helped. On 1/10/23, R1's physician ordered muscle rub to shoulders three times a day for pain and acetaminophen (Tylenol) 650 milligrams (mg) three times a day for shoulder pain. On 2/1/23, the following was observed: At 10:05 a.m. R1 was observed in bed wearing a black pull over t-shirt. R1's t-shirt was covered with white flakes which appeared to be dried skin. The flakes were on R1's shoulders, chest, back, and around the collar of the t-shirt. At 12:52 p.m. nursing assistant (NA)-A and NA-B entered R1's room to get R1 up in the wheelchair. R1 was rolled from side to side to pull up R1's pants. While rolling R1's body and extremities were stiff and ridged, and R1 was resistive. NA-A and NA-B sat R1 up on the edge of the bed. R1 was angry, confused, leaned backwards and complained of left shoulder pain. NA-B exited the room and returned with family member (FM)-C. R1 followed FM-C's direction and transferred into the wheelchair. R1's shirt was not changed, nor was it offered to be changed. At 1:20 p.m. R1's clothes in his closet were observed. R1 had several button up shirts in the closet. On 2/1/23, at 1:22 p.m. at 1:14 p.m. FM-C was interviewed and stated R1 had lots of clothes, and pointed out R1's shirt was covered across the shoulders and around the neck with white flakes of dried skin. FM-C stated while at home, R1 was always well groomed and wore clean clothes. On 2/1/23, at 1:22 p.m. FM-B was interviewed.	F 656	committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Director of Nursing or Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE WATERVIEW WOODS LLC	601 GRANT AVENUE EVELETH, MN 55734

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F 656	Continued From page 7 FM-B stated she visited R1 a couple times a week and had visited R1 the day before. FM-B stated the day before R1 was wearing the same clothes as today, and R1's shirt was covered in the same dried skin flakes. FM-B stated R1 was always clean and well groomed. FM-B stated R1 also had shoulder pain, and in the past would get cortisone shots to relieve the pain. On 2/1/23, at 3:10 p.m. NA-C stated at times it was impossible to get R1's shirt off. NA-C stated R1's body and extremities would become stiff, R1 did not understand, and would become fearful. On 2/2/23, at 10:12 a.m. FM-A was interviewed and stated he visited R1 often, and saw R1 last on the previous Sunday. FM-A stated no staff came into R1's room during the entire visit. FM-A stated R1 had been in the same clothes since the previous Friday. When FM-A requested staff to change R1's clothes, staff stated, "We'll get to that." FM-A stated R1 had button down shirts in his closet which FM-A brought into the facility, because a button down shirt was easier for R1 to get his stiff left arm through. FM-A further stated R1 would never wear soiled clothes or a shirt covered in dried skin flakes. FM-A stated he would expect R1 to be kept clean out of dignity and respect. On 2/2/23, at 10:45 a.m. the director of nursing (DON) was interviewed and stated she would expect R1 to have clean clothes on. If R1 refused, she would expect staff to re-approach and document when R1 refused. The DON verified R1's care plan lacked interventions when R1 refused cares, and she thought using a button up shirt was a good idea.	F 656		

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F 656	Continued From page 8 The facility's Care Planning policy dated 1/6/22, indicated each resident would have a person centered care plan developed for the purpose of meeting the resident's individual medical, physical, psychosocial and functional needs. The goal of a person's centered, individualized care plan was to identify problem areas and develop interventions that were targeted and meaningful to the resident.	F 656		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely repositioning was provided to reduce the risk of pressure ulcers for 1 of 3 residents (R1) reviewed for pressure ulcers. Findings include: The National Pressure Ulcer Advisory Panel (NPUAP) Pressure Injury Stages:	F 686	F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer Immediate Corrective Action: Resident 1 was repositioned. Corrective Action as it applies to others: Care Planning Policy were reviewed and remain current.	2/27/23

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F 686	Continued From page 9 Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis ... the wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister ... Granulation tissue, slough and eschar are not present ... commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel." R1's Diagnosis Report printed 2/7/23, indicated R1's diagnoses included heart disease, abnormal weight loss, dementia, disorientation, anxiety, falls, and pain. R1's quarterly Minimum Data Set (MDS) dated 12/14/22, indicated R1 had severely impaired cognition, and needed extensive assistance of two staff for activities of daily living (ADLs). R1 had a significant weight loss in the past two months, and had one Stage 1 pressure ulcer. In addition, R1's admission MDS dated 10/17/22, indicated R1 had a Stage 2 pressure ulcer which was present on admission. R1's care plan dated 10/13/23 indicated R1 had an alteration skin integrity related to an open area, and immobility related to fall and weakness. Interventions included turn and reposition, or remind R1 to offload (remove pressure from an area of the body) every two hours and as needed. R1 required assistance of two staff with movement in bed. A nursing assistant registered (NAR) Slip dated 2/1/23, and assigned to nursing assistant (NA)-A	F 686	All residents who are at high risk and require repositioning by staff were reviewed to ensure that this reflected on NAR care sheets and care plan. All nurses/TMAs/CNAs were educated on the need to provide repositioning to residents per their individualized care plan. Date of Compliance: 2/27/23 Recurrence will be prevented by: 5 residents who require repositioning assistance will be audited to ensure that they have been repositioned per their individualized care plan. 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: Director of Nursing or Designee	

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F 686	Continued From page 10	F 686		

and NA-B, indicated R1 was to be repositioned every two hours.

Progress notes from 10/10/22, through 2/1/23, indicated the following:
On 10/10/22, R1 indicated he was having occasional pain on his buttocks and tailbone. R1 had a Stage Two open area on his buttocks and tailbone area. The area measured approximately 1 centimeter (cm) by 0.1 cm. A dressing was applied.
On 1/11/23, R1 was seen by wound care for reoccurring pressure area to the coccyx. Wound care's recommendation included wound cleanser, a bordered foam dressing to be change every day and as needed.
On 1/25/23, R1 was seen by wound care and wound was resolved.
On 2/1/23, R1 was seen by wound care for an initial exam of left buttock abrasion.

A Wound Care Follow Up Progress note dated 1/31/23, indicated R1 was seen for a left buttock abrasion. R1 would be going on Hospice. The left buttock abrasion measured 1.5 cm by 0.5 cm by 0.75 cm. Recommendations included wound cleanser and a bordered foam dressing to be changed every other day and as needed. Pressure relief and off loading recommended included the facility pressure ulcer prevention protocol and turn and reposition protocol.

Continual observation on 2/1/23, from 10:05 a.m. through 12:52 p.m. (a total of two hours and 47 minutes) consisted of the following:
At 10:05 a.m. R1 was observed in his room in bed. R1 was awake and laying on his back.
At 12:07 pm. NA-B entered R1's room with the lunch meal and exited R1's room in less than 30

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F 686	Continued From page 11 seconds with the lunch meal. R1 remained in the same position. R1's feet were sticking out from under the covers. R1 had gripper socks on. R1 stated, "I'm still in the same position." At 12:30 p.m. family member (FM)-C arrived, and asked NA-A to get R1 up. NA-A stated it would be a minute. At 12:52 p.m. NA-A and NA-B entered R1's room, checked R1's incontinent brief, put R1's pants on and transferred R1 into the wheelchair. On 2/1/23, at 1:03 p.m. NA-A was asked when R1 was repositioned last. NA-A checked the NAR Slip, and stated R1 was repositioned last at 9:10 a.m. The NAR Slip was reviewed with NA-A. The slip's toileting and repositioning documentation indicated R1 was incontinent at 4:25 a.m., was dry at 7:13 a.m. and 9:10 a.m. At 10:50 a.m. it was documented R1 was "Ok." NA-A verified the toileting and repositioning section lacked a repositioning time. NA-A stated repositioning times were not documented on the NAR Slip. NA-A verified the NAR Slip directed to reposition R1 every two hours. NA-A further verified R1 was not repositioned for three hours and 42 minutes. On 2/1/23, 3:24 p.m. registered nurse (RN)-A was interviewed and stated resident repositioning times should be documented on the NAR slips. RN-A verified the NAR Slip directed to reposition R1 every two hours. RN-A verified if R1 was repositioned last at 9:10 a.m. and not repositioned again until 12:52 p.m. it was more than two hours. RN-A verified R1 was at risk for pressure ulcers due to having previous pressure ulcers which had recently healed. On 2/1/23, at 3:38 p.m. R1's skin was observed with RN-A. RN-A stated stated the open area	F 686		

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F 686	Continued From page 12 looked exactly same as the day before. R1 did not have any new open areas. R1's current open area on his left buttock was pink in color and appeared to be 1.5 cm by 0.5 cm by 0.75 cm. R1 stated his tailbone hurt. On 2/2/23, at 11:14 a.m. the director of nursing (DON) verified R1 was to be repositioned every two hours. The facility's Care Planning policy dated 1/6/22, indicated each resident would have a person centered care plan developed for the purpose of meeting the resident's individual medical, physical, psychosocial and functional needs. The goal of a person's centered, individualized care plan was to identify problem areas and develop interventions that were targeted and meaningful to the resident. The care plan would be utilized to provide care to the resident.	F 686		

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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 2/1/23, and 2/2/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 UNSUBSTANTIATED: H52778054C (MN00090174). The following complaint was found to be SUBSTANTIATED: H52777862C (MN00090476), with licensing orders issued at 4658.0525 Subp.3, 4658.0405 Subp. 3, 626.557 Subp. 3 Please indicate in your electronic plan of correction that you have reviewed these orders and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. 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. 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.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement care plan interventions for refusal of cares for 1 of 3 residents (R1), whose care plans were reviewed. Findings include: R1's Diagnosis Report printed 2/7/23, indicated R1's diagnoses included heart disease, abnormal weight loss, dementia, disorientation, anxiety, falls and pain. R1's quarterly Minimum Data Set (MDS) dated 12/14/22, indicated R1 had severely impaired cognition, and needed extensive assistance of two staff for activities of daily living (ADLs). R1's care plan dated 10/13/22, indicated R1 had a self care deficit related to falls with weakness. Interventions included: assistance of one staff with dressing, personal hygiene and bathing. R1 had an alteration in mood and behavior related to adjustment to the facility, a change in health condition, confusion, anxiety, disorientation, signs	2 565	Corrected	2/27/23

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2 565	Continued From page 3 and symptoms involving cognitive functions and awareness and cerebral vascular accident (stroke). The care plan lacked interventions for when R1 refused to change his shirt due to right shoulder pain. A Minnesota Adult Abuse Reporting Center (MAARC) report filed with the State Agency SA on 1/24/23, indicated the reporter visited R1 a number of times since 10/22, and noticed R1 had not had his clothing changed for four to five days at a time. Progress notes from 10/10/22, through 1/10/23, indicated the following: On 10/10/22, R1 had an impairment in the left upper arm. On 1/9/23, indicated R1 complained of left shoulder pain, and R1 had previously received cortisone injections which had helped. On 1/10/23, R1's physician ordered muscle rub to shoulders three times a day for pain and acetaminophen (Tylenol) 650 milligrams (mg) three times a day for shoulder pain. On 2/1/23, the following was observed: At 10:05 a.m. R1 was observed in bed wearing a black pull over t-shirt. R1's t-shirt was covered with white flakes which appeared to be dried skin. The flakes were on R1's shoulders, chest, back, and around the collar of the t-shirt. At 12:52 p.m. nursing assistant (NA)-A and NA-B entered R1's room to get R1 up in the wheelchair. R1 was rolled from side to side to pull up R1's pants. While rolling R1's body and extremities were stiff and ridged, and R1 was resistive. NA-A and NA-B sat R1 up on the edge of the bed. R1 was angry, confused, leaned backwards and complained of left shoulder pain. NA-B exited the room and returned with family member (FM)-C.	2 565		

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2 565	Continued From page 4 R1 followed FM-C's direction and transferred into the wheelchair. R1's shirt was not changed, nor was it offered to be changed. At 1:20 p.m. R1's clothes in his closet were observed. R1 had several button up shirts in the closet. On 2/1/23, at 1:22 p.m. at 1:14 p.m. FM-C was interviewed and stated R1 had lots of clothes, and pointed out R1's shirt was covered across the shoulders and around the neck with white flakes of dried skin. FM-C stated while at home, R1 was always well groomed and wore clean clothes. On 2/1/23, at 1:22 p.m. FM-B was interviewed. FM-B stated she visited R1 a couple times a week and had visited R1 the day before. FM-B stated the day before R1 was wearing the same clothes as today, and R1's shirt was covered in the same dried skin flakes. FM-B stated R1 was always clean and well groomed. FM-B stated R1 also had shoulder pain, and in the past would get cortisone shots to relieve the pain. On 2/1/23, at 3:10 p.m. NA-C stated at times it was impossible to get R1's shirt off. NA-C stated R1's body and extremities would become stiff, R1 did not understand, and would become fearful. On 2/2/23, at 10:12 a.m. FM-A was interviewed and stated he visited R1 often, and saw R1 last on the previous Sunday. FM-A stated no staff came into R1's room during the entire visit. FM-A stated R1 had been in the same clothes since the previous Friday. When FM-A requested staff to change R1's clothes, staff stated, "We'll get to that." FM-A stated R1 had button down shirts in his closet which FM-A brought into the facility, because a button down shirt was easier for R1 to	2 565		

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2 565	Continued From page 5 get his stiff left arm through. FM-A further stated R1 would never wear soiled clothes or a shirt covered in dried skin flakes. FM-A stated he would expect R1 to be kept clean out of dignity and respect. On 2/2/23, at 10:45 a.m. the director of nursing (DON) was interviewed and stated she would expect R1 to have clean clothes on. If R1 refused, she would expect staff to re-approach and document when R1 refused. The DON verified R1's care plan lacked interventions when R1 refused cares, and she thought using a button up shirt was a good idea. The facility's Care Planning policy dated 1/6/22, indicated each resident would have a person centered care plan developed for the purpose of meeting the resident's individual medical, physical, psychosocial and functional needs. The goal of a person's centered, individualized care plan was to identify problem areas and develop interventions that were targeted and meaningful to the resident. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure careplans were accurate and complete. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		

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2 900	Continued From page 6	2 900		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely repositioning was provided to reduce the risk of pressure ulcers for 1 of 3 residents (R1) reviewed for pressure ulcers. Findings include: The National Pressure Ulcer Advisory Panel (NPUAP) Pressure Injury Stages: Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis ... the wound bed is viable, pink or red, moist, and may also present	2 900	Corrected	2/27/23

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(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) COMPLETE DATE
2 900	Continued From page 7 as an intact or ruptured serum-filled blister ... Granulation tissue, slough and eschar are not present ... commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel." R1's Diagnosis Report printed 2/7/23, indicated R1's diagnoses included heart disease, abnormal weight loss, dementia, disorientation, anxiety, falls, and pain. R1's quarterly Minimum Data Set (MDS) dated 12/14/22, indicated R1 had severely impaired cognition, and needed extensive assistance of two staff for activities of daily living (ADLs). R1 had a significant weight loss in the past two months, and had one Stage 1 pressure ulcer. In addition, R1's admission MDS dated 10/17/22, indicated R1 had a Stage 2 pressure ulcer which was present on admission. R1's care plan dated 10/13/23 indicated R1 had an alteration skin integrity related to an open area, and immobility related to fall and weakness. Interventions included turn and reposition, or remind R1 to offload (remove pressure from an area of the body) every two hours and as needed. R1 required assistance of two staff with movement in bed. A nursing assistant registered (NAR) Slip dated 2/1/23, and assigned to nursing assistant (NA)-A and NA-B, indicated R1 was to be repositioned every two hours. Progress notes from 10/10/22, through 2/1/23, indicated the following: On 10/10/22, R1 indicated he was having occasional pain on his buttocks and tailbone. R1 had a Stage Two open area on his buttocks and	2 900		

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	00583	A. BUILDING: _____ B. WING _____	C 02/02/2023

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2 900	Continued From page 8 tailbone area. The area measured approximately 1 centimeter (cm) by 0.1 cm. A dressing was applied. On 1/11/23, R1 was seen by wound care for reoccurring pressure area to the coccyx. Wound care's recommendation included wound cleanser, a bordered foam dressing to be change every day and as needed. On 1/25/23, R1 was seen by wound care and wound was resolved. On 2/1/23, R1 was seen by wound care for an initial exam of left buttock abrasion. A Wound Care Follow Up Progress note dated 1/31/23, indicated R1 was seen for a left buttock abrasion. R1 would be going on Hospice. The left buttock abrasion measured 1.5 cm by 0.5 cm by 0.75 cm. Recommendations included wound cleanser and a bordered foam dressing to be changed every other day and as needed. Pressure relief and off loading recommended included the facility pressure ulcer prevention protocol and turn and reposition protocol. Continual observation on 2/1/23, from 10:05 a.m. through 12:52 p.m. (a total of two hours and 47 minutes) consisted of the following: At 10:05 a.m. R1 was observed in his room in bed. R1 was awake and laying on his back. At 12:07 pm. NA-B entered R1's room with the lunch meal and exited R1's room in less than 30 seconds with the lunch meal. R1 remained in the same position. R1's feet were sticking out from under the covers. R1 had gripper socks on. R1 stated, "I'm still in the same position." At 12:30 p.m. family member (FM)-C arrived, and asked NA-A to get R1 up. NA-A stated it would be a minute. At 12:52 p.m. NA-A and NA-B entered R1's room, checked R1's incontinent brief, put R1's pants on	2 900		

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2 900	Continued From page 9 and transferred R1 into the wheelchair. On 2/1/23, at 1:03 p.m. NA-A was asked when R1 was repositioned last. NA-A checked the NAR Slip, and stated R1 was repositioned last at 9:10 a.m. The NAR Slip was reviewed with NA-A. The slip's toileting and repositioning documentation indicated R1 was incontinent at 4:25 a.m., was dry at 7:13 a.m. and 9:10 a.m. At 10:50 a.m. it was documented R1 was "Ok." NA-A verified the toileting and repositioning section lacked a repositioning time. NA-A stated repositioning times were not documented on the NAR Slip. NA-A verified the NAR Slip directed to reposition R1 every two hours. NA-A further verified R1 was not repositioned for three hours and 42 minutes. On 2/1/23, 3:24 p.m. registered nurse (RN)-A was interviewed and stated resident repositioning times should be documented on the NAR slips. RN-A verified the NAR Slip directed to reposition R1 every two hours. RN-A verified if R1 was repositioned last at 9:10 a.m. and not repositioned again until 12:52 p.m. it was more than two hours. RN-A verified R1 was at risk for pressure ulcers due to having previous pressure ulcers which had recently healed. On 2/1/23, at 3:38 p.m. R1's skin was observed with RN-A. RN-A stated stated the open area looked exactly same as the day before. R1 did not have any new open areas. R1's current open area on his left buttock was pink in color and appeared to be 1.5 cm by 0.5 cm by 0.75 cm. R1 stated his tailbone hurt. On 2/2/23, at 11:14 a.m. the director of nursing (DON) verified R1 was to be repositioned every two hours.	2 900		

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2 900	Continued From page 10 The facility's Care Planning policy dated 1/6/22, indicated each resident would have a person centered care plan developed for the purpose of meeting the resident's individual medical, physical, psychosocial and functional needs. The goal of a person's centered, individualized care plan was to identify problem areas and develop interventions that were targeted and meaningful to the resident. The care plan would be utilized to provide care to the resident. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could review and revise the pressure ulcer protocol. In addition, the DON could provide education to the nursing staff on the importance of timely turning and repositioning and implementing pressure reducing interventions. The DON could develop a system for the nursing staff to monitor that interventions are implemented. The quality assessment and assurance committee could do random audits of pressure ulcers to ensure residents are receiving the appropriate care and treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
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	21980		2/27/23

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21980	Continued From page 11 reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c.	21980		

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21980	Continued From page 12 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of rough treatment were reported to the State Agency (SA) for 1 of 3 residents (R1) reviewed for abuse. Findings include: R1's Diagnosis Report printed 2/7/23, indicated R1's diagnoses included heart disease, abnormal weight loss, dementia, disorientation, anxiety, falls and pain. R1's quarterly Minimum Data Set (MDS) dated 12/14/22, indicated R1 had severely impaired cognition and needed extensive assistance of two staff for activities of daily living (ADLs). A Minnesota Adult Abuse Reporting Center (MAARC) report filed with the SA on 1/24/23, indicated R1 expressed to the reporter that he was in pain and sustained an injury to his shoulder when a nursing assistant (NA, name unknown) was being rough while changing R1's clothes on the overnight shift of 1/10/23. The NA slammed R1's shoulder against the bedrail. On 2/1/23, at 1:22 p.m. family member (FM)-B was interviewed and stated R1 told her and other family members that a female on the night shift was rough, and bumped his shoulder into the bedrail. On 2/1/23, at 3:24 p.m. registered nurse (RN)-A was interviewed. RN-A stated she had not received any reports regarding alleged abuse from R1, R1's family or from staff. RN-A was then informed R1 reported to his family members he	21980	Corrected	

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21980	Continued From page 13 was treated rough on the night shift of 1/10/23, when a nursing assistant slammed R1's shoulder against the bedrail which cause pain to R1's right shoulder. RN-A stated if she would have received any reports of rough treatment she would have reported it to the SA. On 2/2/23, at 10:12 a.m. FM-A was interviewed and stated he visited R1 often. FM-A stated he had last seen R1 the previous Sunday. FM-A stated during the visit, R1 talked about rough treatment from staff. R1 told FM-A a girl working the night shift banged him around, and hit his right shoulder on the bedrail while changing him. R1 told FM-A he was scared. Upon leaving, R1 stated to FM-A that if FM-A left, R1 would get beat up again. FM-A stated he reported the rough treatment to registered nurse (RN)-A and to other unknown staff. On 2/2/23, at 10:45 a.m. the director of nursing (DON) was interviewed. The DON stated she had not received any reports of rough treatment of R1. The DON was informed the surveyor had reported R1's concerns of rough treatment to RN-A on 2/1/23, at 3:24 p.m. The DON stated she had heard from RN-A that morning there was a concern with R1 with rough cares or unhappy with the cares. The DON stated if rough treatment of a resident was reported to her, she would have done a grievance and done interviews with staff. The DON stated the alleged staff would have been pulled off the schedule pending the investigation, and the incident would reported if necessary. The facility's Abuse Prohibition/Vulnerable Adult policy dated 4/11/22, indicated directed suspicion of neglect, exploitation, or misappropriation of resident property must be reported to the SA not	21980		

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21980	Continued From page 14 later than 2 hours if the incident resulted in serious bodily injury. If the suspected neglect, exploitation, or misappropriation of resident property did not result in serious bodily injury, the report must be made within 24 hours. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse are within appropriate timeframes for reporting. The facility could re-educate staff to policies and procedures, and audit all complaints of alleged abuse or neglect in a measurable and specific way. 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. Those audits should be ongoing and random after compliance is determined by QAPI to ensure compliance is being maintained. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21980		