Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 13, 2021

Administrator
Seasons Healthcare
303 Broadway Avenue South
Trimont, MN 56176

RE: CCN: 245315
Cycle Start Date: May 12, 2021

Dear Administrator:

On July 8, 2021, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 2, 2021

Administrator
Seasons Healthcare
303 Broadway Avenue South
Trimont, MN 56176

RE: CCN: 245315
Cycle Start Date: May 12, 2021

Dear Administrator:

On May 12, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by August 12, 2021 (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 November 12, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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	245315	A. BUILDING ______ B. WING ______	C 05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HEALTHCARE	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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 5/10/21 through 5/12/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5315020C (MN72586), with deficiencies cited at F600 and F609. 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 substantial compliance with the regulations has been attained.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		6/22/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/10/2021

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 600	Continued From page 1 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to intervene and provide supervision and immediate intervene to prevent the physical abuse of 2 of 2 residents (R1 and R3) by a resident with known physically abusive behaviors (R2) to both staff and residents. Findings include: Review of the 5/6/21 at 11:15 a.m., report filed to the State Agency (SA) identified earlier that morning at 5:18 a.m., R1 was sitting quietly in her wheelchair (wc) in the day room. R2 was agitated, walking back and forth in the halls, yelling at nursing staff, slamming doors, and refusing to take oral (PO) medications. R2 walked past the day room, grabbed an empty wc and flipped it upside down. R2 then went over to R1, grabbed the handles of her wc and flipped the chair forward, which caused her to fall face first onto the floor. R2 yelled, "shut up" when staff attempted to intervene and stated, "it could have been worse". R1 was assisted from the floor and an assessment identified she had bleeding and swelling of her nose with small abrasions on her forehead, nose and upper lip. Registered nurse (RN)-C contacted the director of nursing (DON), who gave direction to contact the on-call provider to send R1 to the Emergency Department for Evaluation and Treatment. Review of the 5/12/21, report filed to the SA	F 600	Corrective action for those residents found to have been affected - R1 was sent to the emergency department for evaluation following being tipped out of her wheelchair by R2. R3 was seated in the interior area of the dayroom, so she was not in the traffic area where R2 would wander. To ensure safety of other residents during this incident, they were kept in their rooms. R2 was sent via ambulance to the emergency department and then transferred to a psych unit for treatment. To protect other residents in similar situations our staff will ensure active monitoring of signs and symptoms of aggression/behaviors. If signs and symptoms of willful intent are present other residents will be immediately removed to ensure safety. Other residents are identified by monitoring behaviors of those residents with behavioral and/or psychological diagnosis. Behavior documentation and nursing progress notes, reviewing incident reports and the root cause analysis of each incident and observing day to day interactions among residents will be monitored weekly.	

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F 600	Continued From page 2 identified on 4/17/21 at 9:50 a.m., R3 was seated in her wc by the entrance to the day room, when R2 walked past and slapped her on the back of the head. Registered nurse (RN)-A moved R3 from the entrance area into the day room, away from R2. RN-A assessed R3. No injury was noted. R1's current, undated care plan identified she wandered through out the building in her wc. R1 was identified as at risk for abuse. There was no mention of interventions placed after the 5/6/21 physical abuse by R2. R1's progress notes identified she sustained no injuries from the incident. Observation on 5/10/21 at 2:00 p.m., of R1 identified she had a bruise on her forehead and beneath both eyes which migrated to her left cheek. R1 had 2 small scabbed areas on the top of her nose and upper lip area. R1 was unable to be interviewed due to severe cognitive impairment. R3's 2/23/21, Minimum Data Set (MDS) identified she had severe cognitive impairment, Alzheimer's, dementia with behaviors, major depressive disorder, and anxiety. Her behaviors including yelling out and rejection of care. R3 required extensive assist with all Activities of Daily Living ADLs and was able to assist herself to wander, propelling herself with her feet. R3's current, undated care plan identified behaviors of yelling out, combative resistance to personal cares, in addition to making disruptive sounds when in room or hall. R1 was vulnerable to abuse. There was no mention of any	F 600	Measures/changes put in place to ensure this deficient practice will not recur - All Staff Training was completed on May 20, 2021 regarding Behavior Management including resident to resident abuse and whether the resident behavior towards another was "willful" or "intentional". The DON and/or Resident Life Coordinator will do a quarterly Behavior Education training in August 2021 and November 2021 that will focus on different forms of behaviors and interventions to ensure that staff are knowledgeable about behaviors and how to intervene safely. All new employees and agency staff will continue to be educated on Abuse Prevention. A review of care plans was completed by the Director of Nursing, Resident Life Coordinator and MDS nurse to identify if appropriate interventions are in place. Audits will be performed weekly for the next quarter and reviewed at our monthly and quarterly QA/QAPI meetings. If audit information determines the need for further monitoring, audits will continued to be completed for the following quarter. The facility Nurse to Nurse Report that is completed with potential admissions was reviewed and revised to include gathering more information regarding a potential resident's mood, behavior and psych medication management. The Director of Nursing will audit the Nurse to Nurse reports to ensure that all needed information is included on the report. Leadership will conduct a weekly Behavior Management Huddle beginning the week of June 14th which will be ongoing and it will review behavior documentation and to	

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F 600	Continued From page 3 interventions to keep R3 safe from R2. R2's 5/4/21, Significant Change, MDS identified she had moderate cognitive impairment, Alzheimer's disease, and dementia with behavioral disturbance. R2 was independent with mobility and required supervision with walking in the room/hall. R2's current, undated care plan identified R2 had behavioral symptoms of anger and agitation demonstrated by yelling and hitting at staff and other residents. If staff noticed R2 was agitated, they were to attempt to redirect and encourage to find activities that interested her. Staff were to move any vulnerable residents out of the area, as she paced around the unit. Medications were ordered in an attempt to mange mood and agitation, but R2 would refuse to take medication. R2 was exit seeking at times. R2 was known to enter resident rooms and became combative with attempts at redirection. There was no mention of specific interventions related to R1 and R3 having been assaulted by R2 before, nor the need for immediate supervision if R2 was identified as agitated to prevent further abuse of residents. Interview on 5/10/21 at 4:36 p.m., with nursing assistant (NA)-B identified R1 was pleasant, confused and required total assistance with ADLs. NA-B identified R1 wandered through out the facility, and had not had any concerns of abuse toward other residents noted by staff. NA-B identified R2 had issues with R1 whenever she saw her in the hall or a common area, and were to remove R1 anytime R2 entered an area where she was located. NA-B identified R2 had behaviors of verbal and physical aggression directed toward both residents and staff. NA-B	F 600	assess if interventions are appropriate. A Behavior Management Committee consisting of the DON, MDS Coordinator, Resident Life Coordinator, Administrator and one line staff person was formed on June 22nd, 2021 and will meet monthly to review resident behaviors and interventions being used including psych medications. These findings will be brought to the Monthly and Quarterly QA/QAPI meetings. Monitoring of these changes - The DON or designated individual will audit the Nurse to Nurse Reports for appropriate completion. Staff at the quarterly trainings will complete a knowledge quiz regarding the behavior training materials. Minutes from the Monthly Behavior Meeting will be reviewed at the Monthly and Quarterly QA/QAPI meetings.	

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F 600	Continued From page 4	F 600		

identified staff attempted to redirect R2 to protect other residents and R2 would then turn her aggression toward them yelling, hitting and attempting to bite. NA-B identified R2 was able to move quickly and wandered freely throughout the facility and had demonstrated increased aggressive behaviors over the last couple of weeks.

Interview on 5/11/21 at 10:02 a.m., with RN-B identified R1 was quiet, non-verbal, and wandered aimlessly in the facility. RN-B identified R2 became agitated whenever she saw R1 in the hall or common areas. R2 reacted by getting upset and made comments, such as "what is she doing here!", get her out of here!". If staff did not immediately remove R1 away from the area where R2 was located, R2 would attempt to remove R1 herself. She indicated staff were aware R2 seemed to target R1 and another resident identified as R3 who had cognitive issues and wandered.

Interview on 5/11/21 at 11:41 a.m., with NA-C identified R2's behaviors had been increasing over the past month, demonstrated by increased agitation, taking items and throwing them on the floor, opening and slamming doors and turning on and off lights in resident rooms and common areas. NA-C identified R2 was unpredictable as to how she would respond to conversation or attempts at care, and she felt R2 was a threat to other residents and staff. NA-C stated R2 would walk the halls and if a resident was in an area she entered, she would demand they be removed. NA-C identified staff had to watch and make certain R1 was not close to R2 because she became agitated when she saw her and staff "didn't know what she might do".

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F 600	Continued From page 5	F 600		

Interview on 5/11/21 at 12:10 p.m., with family member (FM)-A identified R2 has developed increased aggression issues over the past couple of months. FM-A identified R2 had been admitted from an independent living setting related to increased memory issues and safety concerns. FM-A stated there had been discussion with the DON about the possibility of R2 being transferred to a geriatric psychiatric facility for evaluation due to her increased behaviors, but there had been problems obtaining admission to a geriatric facility. FM-A stated she was in agreement that R2 should have been sent a couple of weeks earlier for evaluation, but did not recall any attempt to send R2 to the Emergency department or an order to obtain mental health services prior to the incident on 5/6/21.

Interview on 5/11/21 at 12:48 p.m., with the nurse practitioner (NP), identified R2 had demonstrated increased aggression over the past 4 months. She identified, there had been attempted medication intervention, but R2 was non compliant with taking medication. NP-A was aware of an incident (unknown date) when R2 had turned over a snack cart in the hall due to agitation. NP-A made a recommendation that it would be in R2's best interest to obtain an inpatient Geriatric Psychiatric evaluation. Attempts to obtain a geriatric psychiatric admission were not successful due to the requirement of a referral must be made through an acute care emergency setting. The NP felt R2 was a risk for harm directed toward other residents. In the interim, the NP identified she had provided a telephone order for outpatient mental health services, but was not aware if it had taken place. The NP identified her

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F 600	Continued From page 6 expectation was the facility should have contacted the on-call medical provider when R2 demonstrated her agitation by flipping the empty wc/, rather than waiting until after the occurrence immediately after in which R1 was flipped out of her wc. The NP identified immediately following notification of the incident, she had contacted the facility with orders that R2 not to be allowed to return until completion of an inpatient psychiatric evaluation due to risk of harm to self and others. Interview on 5/11/21 at 1:06 p.m., with the DON identified she was aware of R2's agitation and behavior toward staff and residents. She identified that from March of 2021 when she began her employment as DON at the facility she was aware R2's behavior indicated the need for transfer to a geriatric psychiatric unit for evaluation and medication management. She identified the problems encountered for transfer and acceptance to a geriatric psychiatric facility was the required admission from an acute ED referral. The DON identified R2's behaviors had been increasing over the past few months and the NP was seeing her on a weekly basis with attempts to manage her mood and behavior with medication until she was able to be admitted for acute evaluation and medication management. The DON identified the 4/17/21 incident when R2 had struck R3 should have been reported to the SA within the required two hour time frame as abuse. She identified she was not certain why this had not occurred, but would be now submitting the report to the SA. The DON was notified of the on 5/6/21 at 5:19 a.m., when R2 flipped R1 out of her wc. The DON stated she had immediately instructed RN-C to notify the on-call provider and request an order for IM Ativan and advised staff she was on her way to	F 600		

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F 600	Continued From page 7	F 600		

the facility. The on-call provider was contacted and ordered IM Ativan and to transfer R2 via ambulance to the emergency department (ED) for evaluation. Emergency medical services (EMS) were contacted via 911 and responded along with law enforcement. The DON arrived at 5:50 a.m. and with the assistance of two additional nurses administered the Ativan IM. R2 continued physical aggression toward staff, EMS and law enforcement, and resisted transport. NP-A was contacted, and an additional order for a second dose of Ativan IM was obtained at 6:40 a.m.. R2 continued with her agitated and aggressive behavior and refusal to go to ED stating she didn't need help. A Gold Cross advanced life support EMS unit was requested and upon their arrival R2 was medicated with a sedative via nasal administration and allowed EMS to transfer her to the hospital ED. During the process of managing R2, R1 was monitored at the nursing station for safety and once R2 was taken to the ED, EMS was requested to transport R1 to the ED for evaluation of her facial injuries.

Interview on 5/12/21 at 7:15 a.m., with licensed practical nurse (LPN)-A, identified she had worked on the night shift when the incident occurred between R2 and R3. LPN-A voiced her concern with R2 as, "an accident waiting to happen", she identified R2 was frequently up at night wandering the halls, entering other resident rooms, turning on the lights and demanding they get up because she was up. LPN-A indicated R2 was quick and became upset anytime R1 was anywhere near her or in the lounge when R2 entered. If staff didn't respond quickly to remove R1 from the area then R2 would grab her wc/ and shove her out of the area. Staff response was to separate R1 and R2 and place R1 beside the

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F 600	Continued From page 8 nursing station where staff could watch her. LPN-A identified staff had to remove any residents from the area in which R2 was located to insure their safety. LPN-A identified R2 gave no indication of when she was going to become agitated and aggressive toward others. She would be calm and pleasant and suddenly change to agitated and demanding, these behaviors had increased over the last couple of months especially on the night shift. Staff were to keep other residents, especially R1 and R3 away from her when she was in an area. Review of the 3/14/21, Abuse Prohibition & Prevention Plan identified all staff were required to report suspected maltreatment of a Vulnerable Adult (VA) to the DON, Resident Life Coordinator (RLC), Administrator or Charge Nurse. The DON, RLC or Administrator were to oversee completion of the report, ensure the internal investigation began immediately, ensure the appropriate reporting took place and interventions were implemented to provide the VA with a safe environment. All staff must report all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source must be reported immediately but no later than 2 hours after the allegation is made to the DON and Administrator. Attempts to contact RN-A and RN-C for interview, but were unsuccessful.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		6/17/21

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	245315	A. BUILDING ______ B. WING ______	C 05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HEALTHCARE	**303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176**

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F 609	Continued From page 9 §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 allegations of resident to resident physical abuse 2 of 3 residents (R1 and R3) to the State Agency (SA) immediately, but no later than 2 hours. Findings include: Review of the 5/6/21 at 11:15 a.m., report filed to the State Agency (SA) identified earlier that morning at 5:18 a.m., R1 was sitting quietly in her wheelchair (wc) in the day room. R2 was	F 609	Corrective action for those residents found to have been affected - VA reports were filed on 5/12/2021 regarding incidences involving R1 and R3. All Incident Reports from January 1,2021 to current were reviewed for the potential to file a vulnerable adult report. No indications were found, besides the 2 previously mentioned. To identify other residents - following each	

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F 609 Continued From page 10

agitated, walking back and forth in the halls, yelling at nursing staff, slamming doors, and refusing to take oral (PO) medications. R2 walked past the day room, grabbed an empty wc and flipped it upside down. R2 then went over to R1, grabbed the handles of her wc and flipped the chair forward, which caused her to fall face first onto the floor. R2 yelled, "shut up" when staff attempted to intervene and stated, "it could have been worse". R1 was assisted from the floor and an assessment identified she had bleeding and swelling of her nose with small abrasions on her forehead, nose and upper lip. Registered nurse (RN)-C contacted the director of nursing (DON), who gave direction to contact the on-call provider to send R1 to the Emergency Department for Evaluation and Treatment.

Review of the 5/12/21, report filed to the SA identified on 4/17/21 at 9:50 a.m., R3 was seated in her wc by the entrance to the day room, when R2 walked past and slapped her on the back of the head. Registered nurse (RN)-A moved R3 from the entrance area into the day room, away from R2. RN-A assessed R3. No injury was noted.

Interview on 5/11/21 at 1:06 p.m., with the DON identified the 4/17/21 at 7:44 a.m., incident when R2 had struck R3 should have been documented in an incident report, and reported to the SA within the required two hour time frame as abuse. She identified she was not certain why this had not occurred, but would be submitting the report to the SA. On 5/6/21 at 5:19 a.m., the DON identified she had been notified of the incident in which R2 flipped R1 out of her wc. The DON agreed the 5/6/21, report to the SA also had not been made timely within 2 hours.

F 609

incident, the charge nurse will complete an incident report ASAP and will review the appropriate algorithm to determine if the incident needs to be file as a VA report, the charge nurse will also discuss the possible need to file the incident when informing the DON and Administrator of the incident. If found to be reportable a VA will be filed in the appropriate timeframe.

Measures/changes put in place - all nurses received training on May 20, 2021 regarding Vulnerable Adult reporting and reviewed the Abuse Prevention Plan, which was revised to reflect who can submit the initial report so it can be completed timely if the charge nurse is unable to. Nurses were given a copy of the abuse reporting algorithms and a copy of the logging into VA reporting procedure - these were also placed in the Nurses Bible for referencing. Packets were assembled for incident reports that include the question if the incident is reportable and also has attachments of abuse algorithms and VA filing instructions. The pool agency orientation checklist was revised to include training of completing incident reports and filing of VA reports.

Monitoring of these corrections - VA reporting training was completed and audits were completed with all nurses to ensure they were able to go online and file a report. Agency staff will be trained prior to beginning a shift at the facility on how to file a VA report, including timeframe in

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F 609	Continued From page 11 Review of the 3/14/21, Abuse Prohibition & Prevention Plan identified all staff were required to report suspected maltreatment of a Vulnerable Adult (VA) to the DON, Resident Life Coordinator (RLC), Administrator or Charge Nurse. The DON, RLC or Administrator were to oversee completion of the report, ensure the internal investigation began immediately, ensure the appropriate reporting took place and interventions were implemented to provide the VA with a safe environment. All staff must report all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source must be reported immediately but no later than 2 hours after the allegation is made to the DON and Administrator.	F 609	which it needs to be completed. Incident and VA reports are being audited by the DON and/or Administrator for proper completion, including timeframe when a VA report is filed. These audits will be completed daily on all incident reports for 14 days and then will be audited weekly for 3 months. These audits will be reviewed at the Monthly and Quarterly QA/QAPI meetings. Training and monitoring of incident reports and VA reports will be ongoing.	

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
June 2, 2021

Administrator
Seasons Healthcare
303 Broadway Avenue South
Trimont, MN 56176

Re: Event ID: 38U111

Dear Administrator:

The above facility survey was completed on May 12, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

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	00365	A. BUILDING: ____ B. WING ____	C **05/12/2021**

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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 5/10/21 through 5/12/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found to be IN compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE: — (X6) DATE: 06/10/21

Minnesota Department of Health

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2 000	Continued From page 1 be completed. The following complaint was found to be SUBSTANTIATED: H5315020C (MN72586), however NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	2 000		