DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 11, 2023

Administrator
Woodlyn Heights Healthcare Center
2060 Upper 55th Street East
Inver Grove Heights, MN 55077

RE: CCN: 245320
Cycle Start Date: June 1, 2023

Dear Administrator:

On June 28, 2023, we informed you that we may impose enforcement remedies.

On June 29, 2023, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 1, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 1, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 1, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 1, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Woodlyn Heights Healthcare Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 1, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 1, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42

CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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July 11, 2023

Administrator
Woodlyn Heights Healthcare Center
2060 Upper 55th Street East
Inver Grove Heights, MN 55077

Re: Event ID: SMZZ11

Dear Administrator:

The above facility survey was completed on June 29, 2023 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,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING _____ B. WING _____	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLYN HEIGHTS HEALTHCARE CENTER	2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077

(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 6/28/23 and 6/29/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H53203243C (MN94759) and H53203322C (MN94803) with no deficiencies cited. As a result of the investigation the following deficiencies were cited at F609 and F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 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 hours after the allegation is made, if the events that cause the allegation involve abuse or result in	F 609		7/21/23

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

Electronically Signed | 07/21/2023

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 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 an allegation of abuse for 1 of 1 residents (R1) was reported to the State Agency (SA) and administrator no later than two hours after the staff to resident abuse alleged to be observed. Findings include: R1's admssion Minimum Data Set (MDS) dated 6/06/23, indicated R1 was cognitively impaired, had diagnosis of dementia and anxiety with hallucinations and anxiety. In addition, the MDS indicated R1 did not reject care and was assist of one with dressing and toileting. The MDS further indicated R1 was occasionally incontinent of bowel and bladder. During interview 6/28/23 at 2:00 p.m. nursing assistant (NA)-A stated she picked up the	F 609	F 609 PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that	

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F 609	Continued From page 2 evening shift on 6/18/23, and worked with LPN-B and around 7:30 p.m. she observed R1 asleep in her chair, and asked LPN-B to assist to put her to bed. LPN-B, who was more senior, took over and brought R1 into the bathroom and was forcing R1 and instructing NA-A to just put her on the toilet and not letting R1 use the bathroom rails to help assist. NA-A stated R1 was shouting "no, no I am scared" and NA-A revealed LPN-B stated "she is crazy and does not know where she is, this time push". NA-A then stated that we tried to lift R1 up again to get her onto the toilet when LPN-B directed me to just put her into bed with her. NA-A then stated R1 also was resisting getting into be so LPN-B shoved her by the hips onto the bed and pushed her shoulders onto the bed and then R1 said "I have to go to the bathroom god damn you my husband is going to kill you!" NA-A stated she reported this to the administrator the following morning on 6/19/23 (past the 2 hours), and he had asked for a written statement via email. During interview on 6/28/23 at 1:30 p.m., the facility administrator stated he was made aware of the incident from 6/18/23, on the morning of 6/19/23 on the morning by NA-A but was not aware of the extent of the incident and did not feel it was a reportable incident. The administrator did state he suspended LPN-B immediately and assigned more training for LPN-B but did not provide any discipline for the employee. In addition, the administrator indicated he requested NA-A to send a formal document detailing the incident that occurred via email but had not received anything nor followed up to get the information. Review of internal notes from administrator dated	F 609	corrective action was necessary. 1. In continuing compliance with F 609, Reporting of Alleged Violations. Woodlyn Heights Senior Living will 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. Woodlyn Heights will report the results of all investigations to the Executive Director 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 will be taken. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated by 7/21/2023 on the proper procedure for reporting abuse and neglect in a timely manner per state and federal regulations. 3. The Executive Director or designee will audit all facility self reports weekly for 4 weeks and then as needed for timely reporting. 4. As part of Woodlyn Heights Senior Living ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	

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F 609	Continued From page 3 6/19/23, indicated administrator met with NA-A on 6/19/23, about an incident that occurred and NA-A indicated R1 stated she did not want to be changed into her pajamas and was told be LPN-B very loudly that she needed to go to bed. LPN-B said, "You have to go to bed now." NA-A stated R1 was resisting and LPN-B took her hand, pushed the resident back down to bed and said, "you need to go to bed". NA-A stated "that made her feel uncomfortable, so she wanted to report it today." During interview on 6/29/23 at 3:00 p.m. the facility administrator stated he never received an email from NA-A describing the incident that occurred between LPN-B and R1 and after reading the email that was provided (found in his junk mail) he would have immediately reported the incident and investigated. Facility Vulnerable Adult Reporting policy dated 10/19/22, indicated during the shift that alleged abuse/neglect is observed, a mandated reported will immediately make an initial report to their supervisor, after securing the residents safety. Following the review of the situation , the supervisor will immediately report to the Administrator and the Director of nursing. Upon report the Administrator or Director of Nursing shall determine if the incident/allegation meets the criteria for "Reportable Incident". All incidents deemed reportable under MN state are submitted to MDH via the on-line Reporting System immediately.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse,	F 610		7/21/23

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F 610	Continued From page 4 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a thorough investigation for 1 of 1 residents (R1) reviewed for staff to resident abuse. Findings include: R1's admssion Minimum Data Set (MDS) dated 6/06/23, indicated R1 was cognitively impaired, had diagnosis of dementia and anxiety with hallucinations and anxiety. In addition, the MDS indicated R1 did not reject care and was assist of one with dressing and toileting. The MDS further indicated R1 was occasionally incontinent of bowel and bladder. During interview on 6/28/23 at 2:00 p.m. nursing assistant (NA)-A stated she picked up the evening shift on 6/18/23, and worked with LPN-B and around 7:30 p.m. she observed R1 asleep in	F 610	F 610 PLAN OF CORRECTION Woodlyn Heights Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that	

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F 610	Continued From page 5 her chair, and asked LPN-B to assist to put her to bed. LPN-B, who was more senior, took over and brought R1 into the bathroom and was forcing R1 and instructing NA-A to just put her on the toilet and not letting R1 use the bathroom rails to help assist. NA-A stated R1 was shouting "no, no I am scared" and NA-A revealed LPN-B stated "she is crazy and does not know where she is, this time push". NA-A then stated that we tried to lift R1 up again to get her onto the toilet when LPN-B directed me to just put her into bed with her. NA-A then stated R1 also was resisting getting into be so LPN-B shoved her by the hips onto the bed and pushed her shoulders onto the bed and then R1 said "I have to go to the bathroom god damn you my husband is going to kill you!" NA-A stated she reported this to the administrator the following morning on 6/19/23 (past the 2 hours), and he had asked for a written statement via email. During interview on 6/28/23 at 1:30 p.m., the facility administrator stated he was made aware of the incident from 6/18/23, on the morning of 6/19/23 on the morning by NA-A but was not aware of the extent of the incident and did not feel it was a reportable incident. The administrator did state he suspended LPN-B immediately and assigned more training for LPN-B but did not provide any discipline for the employee. In addition, the administrator indicated he requested NA-A to send a formal document detailing the incident that occurred via email but had not received anything nor followed up to get the information. Review of internal notes from administrator dated 6/19/23, indicated administrator met with NA-A on 6/19/23, about an incident that occurred and	F 610	corrective action was necessary. 1. In continuing compliance with F 610, Investigate/Prevent/Correct Alleged Violation. Woodlyn Heights Senior Living will thoroughly investigate all alleged violations and have evidence by documentation, staff interviews, chart review and statements, to prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. All of which will be done in a timely manner that follow state regulations. 2. To correct the deficiency a through investigation was completed for NA-A's allegation for R1staff to resident abuse. The Executive Director and Director of Nursing were educated on the abuse investigation process on 7/21/2023. 3. The Executive Director or designee will audit all self reports for a thorough investigation weekly for 4 weeks and then as needed. 4. As part of Woodlyn Heights Senior Living ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	

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WOODLYN HEIGHTS HEALTHCARE CENTER	2060 UPPER 55TH STREET EAST INVER GROVE HEIGHTS, MN 55077

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F 610	Continued From page 6 NA-A indicated R1 stated she did not want to be changed into her pajamas and was told be LPN-B very loudly that she needed to go to bed. LPN-B said, "You have to go to bed now." LPN-B stated R1 was resisting and LPN-B took her hand, pushed the resident back down to bed and said, "you need to go to bed". NA-A stated "that made her feel uncomfortable, so she wanted to report it today." During interview on 6/29/23 at 3:00 p.m. the facility administrator stated he never received an email from NA-A describing the incident that occurred between LPN-B and R1 and after reading the email that was provided (found in his junk mail) he would have immediately reported the incident and investigated. Review of internal notes from administrator dated 6/19/23, indicated administrator met with NA-A on 6/19/23, about an incident that occurred and NA-A indicated R1 stated she did not want to be changed into her pajamas and was told be LPN-B very loudly that she needed to go to bed. LPN-B said, "You have to go to bed now." NA-A stated R1 was resisting and LPN-B took her hand, pushed the resident back down to bed and said, "you need to go to bed". NA-A stated "that made her feel uncomfortable, so she wanted to report it today." During interview on 6/29/23 at 3:00 p.m. the facility administrator stated he never received an email from NA-A describing the incident that occurred between NA-B and R1 and after reading the email that was provided he would have immediately reported the incident and investigated.	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. BUILDING _____ B. WING _____	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 610	Continued From page 7 The facility internal report lacked evidence the facility interviewed the resident, alleged perpetrator (LPN-A), staff, or other residents as part of an investigation to determine if abuse occurred. Facility Vulnerable Adult Reporting policy dated 10/19/22, indicated during the shift that alleged abuse/neglect is observed, a mandated reported will immediately make an initial report to their supervisor, after securing the residents safety. Following the review of the situation , the supervisor will immediately report to the Administrator and the Director of nursing. Upon report the Administrator or Director of Nursing shall determine if the incident/allegation meets the criteria for "Reportable Incident". All incidents deemed reportable under MN state are submitted to MDH via the on-line Reporting System immediately. In addition the policy indicated the individual identified as suspected for abuse/neglect will be removed from the situation. IF the individual is an employee, they will be suspended pending the completion and outcome of the investigation in addition to disciplinary action will be carried out up to and including, dismissal of employee's as appropriate.	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00829	A. BUILDING: _____ B. WING _____	06/29/2023

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/28/23 and 6/29/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were reviewed: H53203243C (MN94759) and H53203322C	2 000		

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2 000	Continued From page 1 (MN94803). 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, it is required that the facility acknowledge receipt of the electronic documents.	2 000		