Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 5, 2023

Administrator
The Estates At Bloomington LLC
9200 Nicollet Avenue South
Bloomington, MN 55420

RE: CCN: 245324
Cycle Start Date: August 1, 2023

Dear Administrator:

On August 25, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 8, 2023

Administrator
The Estates At Bloomington LLC
9200 Nicollet Avenue South
Bloomington, MN 55420

RE: CCN: 245324
Cycle Start Date: August 1, 2023

Dear Administrator:

On August 1, 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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by November 1, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 1, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 8, 2023

Administrator
The Estates At Bloomington LLC
9200 Nicollet Avenue South
Bloomington, MN 55420

Re: Event ID: MT8T11

Dear Administrator:

The above facility survey was completed on August 1, 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
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
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
	245324	A. BUILDING ______ B. WING ______	C 08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT BLOOMINGTON LLC	**9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/1/23, 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 complaint was reviewed with no deficiency issued: H53244091C (MN95571) The following complaint was reviewed: H53244143C (MN93882) with deficiencies issued 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	F 609		8/18/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 08/14/2023

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 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 potential sexual abuse were reported immediately, but no later than two hours after the allegation is made, to the state agency (SA) for 1 of 1 resident (R4) who alleged being touched "down there" referencing her vaginal area. Findings include: R4's current care plan (CP) dated 10/25/22 indicated R4 was a vulnerable adult and staff were to be aware of statements or signs/symptoms of abuse, if present update Medical Doctor (M.D.), Director of Nursing (DON) and Administrator immediately. Staff were to follow the facility vulnerable adult and abuse reporting policy.	F 609	R4's plan of care was reviewed and updated to reflect past trauma, potential triggers, and interventions. All current residents have the potential to be affected by this deficient practice. Re-education will be provided to all appropriate staff regarding reporting of alleged violations. The Administrator or designee will conduct random audits weekly for 4 weeks to ensure that any alleged violations are identified, properly investigated, and reported according to facility policy and procedure. Audit results will be reviewed by QAPI Committee for further recommendation.	

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F 609		F 609		

Continued From page 2

R4's quarterly Minimum Data Assessment (MDS) dated 6/8/23 indicated R4 had a Brief Inventory of Mental Status (BIMs) score of zero indicating R4 had severe cognitive impairment R4 had unclear speech including slurred or mumbled words. R4 could usually make herself understand could usually understand others. R4 required extensive assistance of two staff members for bed mobility, transfers, dressing, toileting, and bathing. She required the assistance of one staff member for locomotion around the unit. R4's diagnoses included unspecified dementia without behavior disturbances, diabetes, and malnutrition.

Upon interview on 8/1/23 at 9:58 a.m. Family member (FM)-A stated she heard from another family member (FM)-B that R4 reported being touched in a "sexual manner". FM-A stated she is not certain of all the details, except that R4 told FM-B that someone touched her and pointed to her vaginal area as she was crying. FM-A stated she called and reported the allegations to the facility social worker (SW)-A on 5/24/2, to ask if R4 was safe, if the facility was aware of the allegations, and what they have done about the allegations. FM-A was told by SW-A she could not release any information about R4.

Upon interview on 8/1/23 at 12:47 p.m. SW-A stated she did not recall a call from R4's family member. SW-A stated she had heard through the facility that R4's family was saying "something about R4 being touched inappropriately." She stated she was aware that a nurse (RN)-A and another social worker (SW)-B investigated and found that the allegations were not true.

Upon interview on 8/1/23 at 1:00 p.m. registered nurse (RN)-A stated on 5/17/23 FM-B alleged that

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F 609	Continued From page 3	F 609		

someone had been sexually touching R4. RN-A stated SW-B, and her went to speak with R4. R4 was asked if she had been touched and R4 said no. RN-A stated she performed a skin assessment and changed R4's care plan to "cares in pairs" (where two staff are to always assist a resident) to protect R4 and staff from any allegations. RN-A stated the staff reported the incident to the DON and the administrator. She stated they did not to report it to the SA because their findings did not prove abuse happened.

Upon interview on 8/1/23 at 1:24 p.m. FM-B stated he was visiting R4 on 5/17/23 and R4 began to cry. He asked her if she was o.k. and R4 pointed to her vaginal area and stated they touched her. FM-B stated she was victim of abuse as a child, but she has never said anything like that before. FM-B stated he immediately found staff and told SW-B that R4 was crying, pointing to her vagina, and saying someone touched her. FM-B stated he was told "those are really strong allegations, and she does have dementia". FM-B could not recall which staff member made the statement. FM-B stated after hearing the staff mention the strong allegations. He stated he was aware that the allegations were strong, but R4 would not make "anything like that up".

Upon interview on 8/1/23 at 1:40 p.m. SW-B stated on 5/17/23 FM-B came into the office and stated R4 was being touched "down there." She stated her and RN-A went to see R4, who was in the commons area with another family member. SW-B and RN-A asked R4 if she had been touched inappropriately, R4 stated no. SW-B stated staff is aware that R4 is not cognitively intact and is not a reliable reporter. SW-B stated

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F 609	Continued From page 4	F 609		

RN-A performed a skin check immediately and added "cares in pairs" to R4's care plan to be "proactive" to any other allegations. RN-A and SW-B reported the incident to the DON and the administrator that same afternoon. SW-B stated she thought that the facility would be filing a report but was not certain if the allegations were reported to the SA.

Upon interview on 8/1/23 at 2:14 p.m. the DON stated the facility staff intervened right away after they heard of the allegations. The DON was unaware that the allegations included the word "vagina." He stated SW-B and RN-A asked R4 if anything happened, and R4 stated no. He stated the facility did perform a skin assessment immediately just to make sure R4 wasn't harmed and implemented "cares in pairs."

Upon interview on 8/1/23 at 2:26 p.m. the Administrator stated on 5/17/23 RN-A and FM-C came into her office. The Administrator stated she had not heard that the allegations were sexual in nature and if she would have heard the allegations were sexual would have called her regional advisor and asked if the facility should report the allegations to the SA. She stated she was aware that the staff did perform a skin assessment on R4. She was not aware that R4 was put on "cares in pairs" stating that normally "cares in pairs" is not implemented until a resident has multiple allegations against staff and R4 had not.

A policy, titled Monarch Abuse Prohibition/Vulnerable Adult Plan dated 2/2/23, identified "Staff is required to report suspected sexual abuse immediately, but no later than 2 [two] hours after the allegation is made, if the

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F 609	Continued From page 5 events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the event that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator, and Director of Nursing, as well as the appropriate state agencies.	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, 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 lacked evidence the allegation of sexual abuse had been thoroughly investigated for 1 of 1 resident (R4) whose family reported sexual abuse allegations to the facility. The findings include:	F 610	Report was filed with OHFC regarding alleged allegations on 08/01/2023. R4's plan of care was reviewed and updated to reflect past trauma, potential triggers, and interventions. All current residents have the potential to be affected by this deficient practice. Re-education will be provided to all	8/18/23

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F 610	Continued From page 6 R4's current care plan (CP) dated 10/25/22 indicated R4 was a vulnerable adult and staff was to be aware of statements or signs/symptoms of abuse, if present update Medical Doctor (M.D.), Director of Nursing (DON) and Administrator immediately. Staff were to follow the facility vulnerable adult and abuse reporting policy. R4's quarterly Minimum Data Assessment (MDS) dated 6/8/23 indicated R4 had a Brief Inventory of Mental Status (BIMs) score of zero indicating R4 had severe cognitive impairment R4 had unclear speech including slurred or mumbled words. R4 could usually make herself understand could usually understand others. R4 required extensive assistance of two staff members for bed mobility, transfers, dressing, toileting, and bathing. She required the assistance of one staff member for locomotion around the unit. R4's diagnoses included unspecified dementia without behavior disturbances, diabetes, and malnutrition. R4's weekly skin inspection dated 5/17/23 at 2:10 p.m. under the title summary of current skin condition indicated R4 had purple discoloration on her lower right arm. Skin, warm, dry, and intact. R4 progress note dated 5/17/23 at 12:50 p.m. was late entry indicated R4's son approached social worker (SW)-B and registered nurse (RN)-A stating that his mother is crying. SW-B and RN-A went to commons area where R4 was sitting with two family members. R4 denied pain. FM-C asked R4 if anything was troubling her, and R4 stated no. R4's Clinical Resident Profile updated indicated under the column special instruction "cares in pairs" (resident is to have two staff for all cares).	F 610	appropriate staff regarding investigating, preventing, and/or correcting alleged violations. The Administrator or designee will conduct random audits weekly for 4 weeks to ensure that any alleged violations are identified, properly investigated, and reported according to facility policy and procedure. Audit results will be reviewed by QAPI Committee for further recommendation.	

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F 610	Continued From page 7	F 610		

Upon interview on 8/1/23 at 9:58 a.m. Family Member (FM)-A stated she heard from another family member (FM)-B that R4 reported being touched in a "sexual manner". FM-A stated she is not certain of all the details, except that R4 told FM-B that someone touched her and pointed to her vaginal area as she was crying. FM-A stated she called and reported the allegations to the social worker (SW)-A on 5/24/23, asked if R4 was safe, if the facility was aware of the allegations, and what they have done about the allegations. FM-A was told by SW-A she could not release any information about R4.

Upon interview on 8/1/23 at 12:47 p.m. SW-A stated she did not recall a call from R4's family member. SW-A stated she had heard through the facility that R4's family was saying "something about R4 being touched inappropriately." She stated she was aware that (RN)-A and another social worker (SW)-B investigated and found that the allegations were not true.

Upon interview on 8/1/23 at 1:00 p.m. registered nurse (RN)-A stated on 5/17/23 FM-B came into her office alleging that someone had been sexually touching R4. RN-A stated SW-B, and her went to speak with R4. R4 was asked if she had been touched and R4 said no. RN-A stated she performed a skin assessment and changed R4's care plan to "cares in pairs." RN-A denied interviewing FM-B further following the initial question. RN-A stated she interviewed R4's roommate, however, did not provide any documentation. She stated she did not interview any staff members of sexual abuse allegation. RN-A stated she would have completed interviews if the allegations would have been

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F 610	Continued From page 8	F 610		

found true. RN-A stated she would look for an investigation soft file on R4 to see if any other staff had made a file with more information. RN-A returned at 3:10 p.m. with copies of the weekly skin assessment completed on 5/17/23 and the client profile indicating R4 was to have "cares in pairs." RN-A stated she could find any other related information on R4.

Upon interview on 8/1/23 at 1:24 p.m. FM-B stated he was visiting R4 on 5/17/23 and R4 began to cry. He asked her if she was o.k. and R4 pointed to her vaginal area and stated they touched her. FM-B stated she was victim of abuse as a child, but she has never said anything like that before. FM-B stated he immediately found staff and told SW-B that R4 was crying, pointing to her vagina, and saying someone touched her. FM-B state the facility is only allowing female staff to work with R4 since the allegations. He was not aware of any other facility interventions.

Upon interview on 8/1/23 at 1:40 p.m. SW-B stated on 5/17/23 FM-B came into the office and stated R4 was being touched "down there." She stated her and RN-A went to see R4, who was in the commons area with another family member. SW-B and RN-A asked R4 if she had been touched inappropriately, R4 stated no. SW-B stated she was not certain if the allegations were something that happened that day or something that happened a while ago and R4 just mentioned it when family was visiting. SW-B denied interviewing any other residents or staff at the time of the allegations.

Upon interview on 8/1/23 at 11:19 a.m. nursing assistant (NA)-A stated she works with R4 often

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. BUILDING ______ B. WING ______	C 08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT BLOOMINGTON LLC	**9200 NICOLLET AVENUE SOUTH BLOOMINGTON, MN 55420**

(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
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and she was not aware that R4 was a "cares in pairs" resident. She denied any interviews or education regarding any allegations regarding R4.

Upon interview on 8/1/23 at 3:05 p.m. nursing assistance (NA)-B stated she is the main care giver for R4 during the day shift. She stated she has not heard any abuse allegations from R4 or R4's family. She stated she was aware that R4 was to have "cares in pairs." NA-A stated she heard the reason for the "cares in pairs" was because either R4 or her family complained about sexual abuse from staff. NA-A could not recall how she heard it, stating it was a while ago.

Upon interview on 8/1/23 at 2:14 p.m. the DON stated the facility staff intervened right away after they heard of the allegations. The DON was unaware that the allegations included the word "vagina." He stated SW-B and RN-A asked R4 if anything happened, and R4 stated no. He stated the facility completed a skin assessment just to make sure R4 wasn't harmed and "cares in pairs" was implemented immediately. The DON denied being any part of the investigation on R4.

Upon interview on 8/1/23 at 2:26 p.m. the Administrator stated on 5/17/23 RN-A and FM-C came into her office. The administrator stated she was under the impression that FM-B had stated staff was rough with R4. The Administrator stated she had not heard that the allegations were sexual in nature. She stated she was aware that the staff perform a skin assessment on R4. She was not aware that R4 was put on "cares in pairs." The Administrator denied being any part of the investigation on R4.

A facility policy titled Abuse Prohibition/Vulnerable

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F 610	Continued From page 10 Adult Plan dated 2/2/23, indicated the investigation team will review all incident reports regarding residents including those that indicate an injury of unknown origin, abuse, neglect, misappropriation of property or involuntary seclusion. Investigation will begin immediately. Staff will take immediate and appropriate actions to prevent further abuse, neglect, exploitation, and mistreatment from occurring while the investigation is in process. The investigation team will determine if further investigation is needed. The designated person will notify the designated agency. The investigate team will continue the investigation. The investigation may include interviewing staff, residents, or other witness. All documentation will be kept in a confidential file in the facility. A summary which identified trends or patterns will be forwarded to QAPI. The social workers and other staff as appropriate will provide ongoing support and counseling to the resident and family as needed. Facility will ensure proper follow-up communication related to the incident across all shifts and to practitioners and resident representatives as applicable.	F 610		

Minnesota Department of Health

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	00169	A. BUILDING: ______ B. WING ______	C 08/01/2023

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/1/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed: H53244091C (MN95571), H53244143C	2 000		

Minnesota Department of Health

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2 000	Continued From page 1 (MN93882) 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		