Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 28, 2024

Administrator
Cura of Le Sueur
621 South 4th Street
Le Sueur, MN 56058

RE: CCN: 245416
Cycle Start Date: March 27, 2024

Dear Administrator:

On June 17, 2024, 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 28, 2024

Administrator
Cura of Le Sueur
621 South 4th Street
Le Sueur, MN 56058

Re: Reinspection Results
Event ID: HOU212

Dear Administrator:

On June 17, 2024, survey staff of the Minnesota Department of Health - Health Regulation Division, completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 2, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 22, 2024

Administrator
Cura of Le Sueur
621 South 4th Street
Le Sueur, MN 56058

RE: CCN: 245416
Cycle Start Date: March 27, 2024

Dear Administrator:

On April 9, 2024, we informed you that we may impose enforcement remedies.

On May 2, 2024, 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 location for imposition. The CMS location 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 June 27, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 27, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 27, 2024.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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 June 27, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Cura of Le Sueur will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 27, 2024. 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 September 27, 2024 (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://forms.web.health.state.mn.us/form/NHDisputeResolution

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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 22, 2024

Administrator
Cura of Le Sueur
621 South 4th Street
Le Sueur, MN 56058

Re: State Nursing Home Licensing Orders
Event ID: HOU211

Dear Administrator:

The above facility was surveyed on May 1, 2024, through May 2, 2024, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

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

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00336	A. BUILDING: ______ B. WING ______	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURA OF LE SUEUR	621 SOUTH 4TH STREET LE SUEUR, MN 56058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments	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 5/1/24 through 5/2/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and

Minnesota Department of Health

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	00336	A. BUILDING: ____ B. WING ____	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURA OF LE SUEUR	**621 SOUTH 4TH STREET LE SUEUR, MN 56058**

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed. H54163477C (MN00102951, MN00102945) with no licensing orders issued. As a result of the investigation, licensing orders were issued at (0830). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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	00336	A. BUILDING: ____ B. WING ____	05/02/2024

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to implement Self Care plan interventions for 1 of 3 residents (R1) which put R1 at risk for falls during provisions of care. Findings include: R1's significant change Minimum Data Set (MDS), dated 4/12/24, identified R1 was dependent with sit to stand and chair/bed-to-chair transfers and did not make efforts to complete	2 830	corrected	6/15/24

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	00336	A. BUILDING: ______ B. WING ______	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 3	2 830		

these activities. MDS indicated a diagnosis of hypertension, hyperlipidemia, hip fracture, stroke, seizure disorder, and malnutrition. R1 had a fall on 4/1/24 resulting in a right hip fracture.

R1's Self Care plan, revised on 4/5/24, identified R1 was an assist of two, non-weight bearing on right leg for transfers, assist of one with wheelchair, non-weight bearing on right leg, and unable to ambulate in room at this time.

Observations on 5/1/24 at 3:29 p.m., R1 was sitting at edge of the bed with wheelchair next to the bed. No transfer belt was observed in R1 room.

During interview on 5/1/24 at 3:29 p.m., R1 stated (NA)-B had finished her shower and took R1 back to her room in a wheelchair and NA-B told her, "we are going to do this now", then NA-B placed their arms under R1's arms and "dropped me in my bed". R1 stated her right inner knee had a scrape due to the placement into bed. R1 indicated she was unaware how many staff should be assisting with transfers but recalled only one staff was present during the transfer.

During interview on 5/2/24 at 10:38 a.m., NA-B stated R1 was transferred with one staff person during the reported incident. NA-B indicated she was not aware R1 was a two-person transfer and had always transferred R1 alone. NA-B also confirmed she was unaware R1 was non-weight bearing on right side due to a right hip fracture adding, floor nurses would usually update aides on changes to care plans.

During phone call interview on 5/2/24 at 11:41 a.m., assistance director of nursing (ADON) stated a nurse had reported R1's concerns with

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	00336	A. BUILDING: ______ B. WING ______	05/02/2024

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2 830	Continued From page 4	2 830		

NA-B. ADON stated an interview with R1 was completed along with a body check indicating no injuries except a skin tare on her elbow. ADON stated staff are to never transfer a resident under their arms and are to always use a transfer belt. ADON also stated there had been no review of R1's care plan during the investigation, so it was not determined the care plan had not been followed. Lastly, ADON confirmed no re-education with NA-B or facility care staff had been completed regarding following the care plan or safe transfers since the incident review, only re-education on abuse.

During interview on 5/2/24 at 12:24 p.m., nursing assistance (NA)-A stated when R1 transfers she would stand and then self-pivot to the bed. NA-A indicated a transfer belt should be used however, R1 refused most times so, "I don't really ask any more". During interview NA-A reviewed R1's care plan Kardex and confirmed transfer instructions as two-person transfer assist, non-wight bearing pivot transfers. NA-A stated R1 had never been transferred with 2 people. NA-A further explained she had never been trained to check the care plan Kardex on the IPAD before a shift but rather nursing would tell the aides if there were changes.

During interview on 5/2/24 at 1:06 p.m., director of nursing (DON) stated the incident had been investigated and concluded no abuse occurred. DON stated the care plan was reviewed and, "I believe it was followed" with two-staff assisting in transfers, however DON could not recall another aide being with NA-B during incident transfer. DON explained when there were changes in a care plan for any of the residents, there was a notice on the Kardex identifying a change and staff are to review it. DON stated aides were

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2 830	Continued From page 5 expected to use the IPADs to review the Kardex before each shift and staff had been trained. DON was not aware staff were not using IPADs before each shift. Facility policy titled Using the Care Plan, effective date 8/2021, indicated a policy statement the care plan should be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. Completed care plans are located in the electronic health record. CNAs are responsible for reporting to the nurse supervisor any changes in the resident's condition and care plan goals and objectives that have not been met or expected outcomes that have not been achieve. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245416	A. BUILDING ______ B. WING ______	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURA OF LE SUEUR	621 SOUTH 4TH STREET LE SUEUR, MN 56058

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F 000	INITIAL COMMENTS On 5/1/24 through 5/2/24, 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: H54163477C (MN00102951, MN00102945) with no deficiencies issued. As a result of the investigation, deficiencies were issued at F610 and F689. 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 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,	F 610		6/15/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/29/2024

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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	245416	A. BUILDING ______ B. WING ______	C 05/02/2024

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F 610	Continued From page 1 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 observation, interview and document review the facility failed to complete a thorough investigation when 1 of 1 residents (R1) alleged staff to resident abuse and the care plan was not reviewed to ensure all provisions of care were being adequately implemented. This put R1 at risk for future accidents when, during review, it was determined staff were not implementing transfer interventions as care planned. Findings include: A Facility Reported Incident (FRI) report, submitted to the State Agency (SA) on 4/30/24 at 2:00 p.m., indicated R1 had been picked up by alleged perpetrator (AP)/nursing assistant (NA-B) from the wheelchair and thrown into bed. A Facility Investigation 4/30/24, identified R1 reported to staff an allegation of abuse when NA-B picked her up from the wheelchair and threw her into bed. Report identified a police report was filed and, at that time, R1 denied there was abuse. AP was suspended during investigation and returned to work after education was completed on abuse. R1 was assessed by assistant director of nursing (ADON) resulting in a	F 610	The facility will conduct a full and thorough investigation into the complaint pertaining to R1. This will involve reviewing all relevant documentation, interviewing staff and residents as necessary, and documenting all findings. The residents care plan was updated to reflect current care needs and preferences. The facility will review all complaints received within the past six months to ensure that all have been thoroughly investigated. Any complaints found to have not been fully investigated will be addressed immediately. The facility will review its complaint investigation policies and procedures to ensure all complaints are thoroughly investigated. This will include a timeline for investigation, a requirement for documentation of all findings, and a process for escalating and resolving issues. IDT staff will be trained on these new procedures.	

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F 610	Continued From page 2 skin tare on elbow however, no other injuries or pain noted. Finding were identified as no abuse occurred. R1's significant change Minimum Data Set (MDS), dated 4/12/24, identified R1 was dependent with sit to stand and chair/bed-to-chair transfers and did not make efforts to complete these activities. MDS indicated R1 was diagnoses with hypertension, hyperlipidemia, hip fracture, stroke, seizure disorder, and malnutrition. R1 had a fall on 4/1/24 resulting with in a right hip fracture. R1's Self Care care plan, revised on 4/5/24, identified R1 was an assist of two non-weight bearing on right leg for transfers, assist of one with wheelchair, non-weight bearing on right leg, and unable to ambulate in room at this time. During interview on 5/1/24 at 3:29 p.m., R1 stated (NA)-B had finished her shower and took R1 back to her room in a wheelchair and NA-B told her, "we are going to do this now," then NA-B placed their arms under R1's arms and "dropped me in my bed". R1 stated her right inner knee had a scrape due to the placement into bed. R1 indicated she was unaware how many staff should be assisting with transfers but recalled only one staff was present during the transfer. During interview on 5/2/24 at 10:38 a.m., NA-B stated R1 was transferred with one staff person during the reported incident and NA-B indicated she was not aware R1 was a two-person transfer and had always transferred R1 alone. NA-B explained during the incident, R1 stood up, faced her bed and fell to the left side into the bed. NA-B was the only staff present for the transfer. NA-B	F 610		

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F 610	Continued From page 3 also confirmed she was unaware R1 was non-weight bearing on right side due to a right hip fracture adding, floor nurses would usually update aides on changes to care plans. During phone call interview on 5/2/24 at 11:41 a.m., ADON stated a nurse had reported R1's concerns with NA-B which alleged she had been thrown into bed by AP. ADON stated an interview with R1 was completed along with a body check indicating no injuries except a skin tare on her elbow. ADON stated staff are to never transfer a resident under their arms and are to always use a transfer belt. ADON also stated there had been no review of R1 care plan during the investigation, so it was not determined the care plan had not been followed. Lastly, ADON confirmed there had been no re-education or competency testing with NA-B or facility care staff regarding following the care plan or safe transfers since allegation, only re-education on abuse. During interview on 5/2/24 at 1:06 p.m., director of nursing (DON) stated the incident had been investigated and concluded no abuse occurred. DON stated the care plan was reviewed and, "I believe it was followed" with two-staff assisting in transfers, however DON could not recall another aide being with NA-B during transfer.	F 610		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		6/15/24

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F 689	Continued From page 4 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement Self Care plan interventions for 1 of 3 residents (R1) which put R1 at risk for falls during provisions of care. Findings include: R1's significant change Minimum Data Set (MDS), dated 4/12/24, identified R1 was dependent with sit to stand and chair/bed-to-chair transfers and did not make efforts to complete these activities. MDS indicated a diagnosis of hypertension, hyperlipidemia, hip fracture, stroke, seizure disorder, and malnutrition. R1 had a fall on 4/1/24 resulting in a right hip fracture. R1's Self Care plan, revised on 4/5/24, identified R1 was an assist of two, non-weight bearing on right leg for transfers, assist of one with wheelchair, non-weight bearing on right leg, and unable to ambulate in room at this time. Observations on 5/1/24 at 3:29 p.m., R1 was sitting at edge of the bed with wheelchair next to the bed. No transfer belt was observed in R1 room. During interview on 5/1/24 at 3:29 p.m., R1 stated NA-B had finished her shower and took R1 back to her room in a wheelchair and NA-B told her, "we are going to do this now," then NA-B placed their arms under R1's arms and "dropped me in my bed". R1 stated her right inner knee had a scrape due to the placement into bed. R1 indicated she was unaware how many staff	F 689	The facility will immediately review and follow the two-assist care plan for R1. Any deviations from the plan will be corrected, and all staff involved in the resident's care will be re-educated on the specifics of the two-assist care plan. The facility will conduct a review of all residents who have a two-assist care plan to ensure that their care plans are being followed accurately and consistently. Any deviations identified will be corrected. The facility will provide training to all care staff on the importance of following care plans/kardex, with specific emphasis on two-assist care plans. The facility will conduct weekly audits for the next three months to ensure that all two-assist care plans are being followed. The results of these audits will be reviewed by the Quality Assurance and Process Improvement (QAPI) team and any non-compliance will be addressed immediately.	

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F 689	Continued From page 5	F 689		

should be assisting with transfers but recalled only one staff was present during the transfer.

During interview on 5/2/24 at 10:38 a.m., NA-B stated R1 was transferred with one staff person during the reported incident. NA-B indicated she was not aware R1 was a two-person transfer and had always transferred R1 alone. NA-B also confirmed she was unaware R1 was non-weight bearing on right side due to a right hip fracture adding, floor nurses would usually update aides on changes to care plans.

During phone call interview on 5/2/24 at 11:41 a.m., assistance director of nursing (ADON) stated a nurse had reported R1's concerns with NA-B. ADON stated an interview with R1 was completed along with a body check indicating no injuries except a skin tare on her elbow. ADON stated staff are to never transfer a resident under their arms and are to always use a transfer belt. ADON also stated there had been no review of R1's care plan during the investigation, so it was not determined the care plan had not been followed. Lastly, ADON confirmed no re-education with NA-B or facility care staff had been completed regarding following the care plan or safe transfers since the incident review, only re-education on abuse.

During interview on 5/2/24 at 12:24 p.m., nursing assistance (NA)-A stated when R1 transfers she would stand and then self-pivot to the bed. NA-A indicated a transfer belt should be used however, R1 refused most times so, "I don't really ask any more". During interview NA-A reviewed R1's care plan Kardex and confirmed transfer instructions as two-person transfer assist, non-wight bearing pivot transfers. NA-A stated R1 had never been

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F 689	Continued From page 6	F 689		

transferred with two people. NA-A further explained she had never been trained to check the care plan Kardex on the IPAD before a shift but rather nursing would tell the aides if there were changes.

During interview on 5/2/24 at 1:06 p.m., director of nursing (DON) stated the incident had been investigated and concluded no abuse occurred. DON stated the care plan was reviewed and, "I believe it was followed" with two-staff assisting in transfers, however DON could not recall another aide being with NA-B during incident transfer. DON explained when there were changes in a care plan for any of the residents, there was a notice on the Kardex identifying a change and staff are to review it. DON stated aides were expected to use the IPADs to review the Kardex before each shift and staff had been trained. DON was not aware staff were not using IPADs before each shift.

Facility policy titled Using the Care Plan, effective date 8/2021, indicated a policy statement the care plan should be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. Completed care plans are located in the electronic health record. CNAs are responsible for reporting to the nurse supervisor any changes in the resident's condition and care plan goals and objectives that have not been met or expected outcomes that have not been achieve.