



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
March 6, 2024

Administrator  
Sylvan Court  
112 St Olaf Avenue South  
Canby, MN 56220

RE: CCN: 245433  
Cycle Start Date: February 14, 2024

Dear Administrator:

On February 14, 2024, 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:

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](mailto: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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by May 14, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 14, 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/lrc\\_idr.cfm](https://mdhprovidercontent.web.health.state.mn.us/lrc_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](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.

Sylvan Court  
March 6, 2024  
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Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive style with a loop at the end of the last name.

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



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March 6, 2024

Administrator  
Sylvan Court  
112 St Olaf Avenue South  
Canby, MN 56220

Re: Event ID: VV2X11

Dear Administrator:

The above facility survey was completed on February 14, 2024 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,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245433</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>02/14/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SYLVAN COURT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>112 ST OLAF AVENUE SOUTH CANBY, MN 56220</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>On 2/13/24, through 2/14/24, 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.</p> <p>The following complaints were reviewed. H54339613C (MN100666), H54339614C (MN100667)</p> <p>As a result of the investigation, F609 and F610 were issued.</p> <p>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.</p> <p>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.</p>	F 000		
F 609 SS=D	<p><b>Reporting of Alleged Violations</b> CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§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</p>	F 609		3/18/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>03/14/2024</b>
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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	<p>Continued From page 1</p> <p>hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§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:</p> <p>Based on interview and document review, the facility failed to immediately report to the administrator and failed to immediately report, no later than 2 hours, to the State Agency (SA) an allegation of staff to resident abuse for 1 of 3 residents (R2) who were reviewed for staff to resident abuse.</p> <p>Findings included:</p> <p>R2's quarterly Minimum Data Set dated 1/4/24, identified moderately impaired cognition.</p> <p>Facility internal live event documentation dated 2/6/24 at 12:03 a.m. identified event type safety/security event and threatening behavior/verbal assault. R2 displayed exit seeking behaviors via second floor door,</p>	F 609	<p>Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.</p> <p>1. What corrective action will be</p>	

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F 609	<p>Continued From page 2</p> <p>unsuccessful. Cares provided to another resident by registered nurse (RN)-A and nursing assistant (NA)-A, when finished R2 was no where to be found. First floor staff informed second floor staff R2 had used the elevator to access first floor. R2 brought back to second floor and constantly monitored. R2 was constantly furious and physical to NA-A when kept safe. Director of nursing (DON) notified at 12:31 a.m.. R2 sustained a large dark purple bruise measuring 14.5 centimeters (cm) x 6.3 cm tender to touch to left forearm as a result of incident. R2 stated "that witch squeezed my arm". Intervention identified: monitor to determine possible harm. DON was notified of bruise at 6:40 a.m. DON interviewed both RN-A and NA-A. NA-A noted resident became aggressive punching RN-A in buttock and stomach. NA-A reported she grabbed R2's arm to divert the situation but did not intend harm. R2 currently prescribed aspirin and prednisone (steroid) at risk for bruising and fragile skin.</p> <p>R2's progress notes from 2/6/24, through 2/7/24, identified:</p> <p>-2/6/24 at 12:30 a.m. (notes revised at 9:52 a.m.) R2 was found walking out of her room with rolling table unassisted. R2 stated loudly and insistentlly I want to go out and sit on that chair and pointed at the chair at nurse's station. Encouraged and assisted R2 back to her room to the wheelchair to be safe and allowed to roam around her room. R2 refused, got furious and punch nurse in right chest and right wide of stomach and tried to head bang nurse's face with hers. R2 roamed around the floor while RN-1 and NA-A toileted another resident, left the floor via elevator, and was found shortly afterwards on first floor. R2 was brought back up to second floor, secured doors by</p>	F 609	<p>accomplished for those residents found to have been affected by the deficient practice?</p> <p>On of before 2.27.24, reviewed education with RN-A and CNA-A on reporting of abuse and neglect.</p> <p>Employee relations interviewed and followed corrective action process for NA-A. NA-A returned to work on evening shift. Prior to this additional education was completed on code of conduct. NA-A did complete management of aggressive behavior course on 2.27.24.</p> <p>2.How will other residents, having the potential to be affected by the same deficient practice, be identified?</p> <p>All residents in the facility have the potential to be affected by this practice. All staff will receive education on appropriate reporting of abuse and neglect with competency demonstrated by a quiz. Review occurred for all incident reports for the last 30 days from the dates of 1.15.24-2.15.24 and determined all incidents were properly reviewed, investigated, and reported as necessary.</p> <p>3.What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur?</p> <p>All staff will receive education on appropriate reporting of abuse and neglect with competency demonstrated by</p>	

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F 609	<p>Continued From page 3</p> <p>shutting them and kept her closely monitored. R2 was constantly furious and physical to NA-A when kept safe. DON notified. Maintenance will be notified in the morning to request for a wander guard, per DON.</p> <p>-2/6/24 at 6:40 a.m. (notes revised at 2:43 p.m.) Night nurse reported to writer there was an injury to R2's left arm from staff/resident altercation during the night. Writer checked arm with night nurse present. Bruise noted measuring 14.5 x 6.3 centimeters (cm), dark purple with slight swelling in the middle. Skin intact and tender to the touch. The resident reported "that witch squeezed my arm". Monitor daily and take weekly measurements. Resident was on aspirin 81 milligram (mg) daily. DON notified immediately.</p> <p>Progress notes did not identify when night nurse was notified of interactions between NA-A and R2's bruise.</p> <p>During an interview on 2/14/24 at 10:00 a.m. NA-B stated came into work and arrived at 2:00 a.m. NA-B indicated around approximately 3:30 a.m. NA-A radioed for assistance on 2nd floor with R2. NA-B went up to 2nd floor to assist and saw NA-A held R2's door shut and R2 yelled let me out while she pulled on the door from inside her room. NA-B requested NA-A remove her hand from the closed door handle and asked R2 let go of door, go to middle of room so she could be assisted. NA-B entered R2's room, calmed her down, and assisted her to the bathroom. NA-B verified R2 was scared, shaking, and asked to not be left alone. NA-B stated R2's left arm long sleeve was pushed up a bit and noticed her left lower arm had a dark purple bruise that covered 75% of her arm. NA-B stated R2 said to her "that</p>	F 609	<p>a quiz.</p> <p>4.How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur?</p> <p>DON or designee will implement an audit to assess if staff are reporting any situations of abuse and neglect by completing scenario and situational based assessment. This audit will be conducted for 3 months and then will re-evaluate need for continuation. Results of the audit will be brought forward to the QAPI meeting for further recommendations.</p> <p>DON/Designee, Administrator, or Improvement Advisor will review of all incidents in the facility weekly for 4 weeks, and every other week for 4 weeks. Results of these audits will be brought forward to the QAPI committee for further recommendations.</p>	

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F 609	<p>Continued From page 4</p> <p>bitch did that to me, grabbed my arm and squeezed it hard". NA-B stated after she assisted R2 back to bed reported to RN-A approximately 2:15 a.m. all details regarding the incident between R2 and NA-A when she arrived up to 2nd floor and the large bruise she had found on R2's left lower arm R2 asked NA-B not to leave and reassurance was given.</p> <p>During an interview on 2/16/24 at 9:30 a.m. RN-A stated R2 was usually calm and her confusion had progressed in the past month or so. RN-A stated R2 required assist of two staff to toilet her or one depending on her condition that day. RN-A stated unsure what triggered R2's behaviors the night of the incident, and had never been combative or hard headed prior to this incident. RN-A stated at approximately 2:15 a.m. NA-B assisted NA-A with R2. NA-B returned to first floor and informed RN-A R2 had something on her left arm that needed to be looked at. RN-A stated she informed NA-B it would be checked later. RN-A stated she waited until 4:00 a.m. and R2 was sleeping, decided not to bother her, and waited until change of shift. RN-A stated around 6:30 a.m. (over 4 hours later) along with LPN-A went in and assessed R2's left arm and found a large purple bruise measured approximately to 10 to 14 centimeters (cm) and 4 cm across, bulging lump on top, and painful. RN-A verified only one call was made to the DON at 12:00 a.m. during the night shift regarding R2 and her change in behavior.</p> <p>RN-A failed to report the alleged abuse, interview R2 and remove potential staff from working with R2 to ensure R2's safety.</p> <p>During an interview on 2/14/24 at 4:45 p.m. DON</p>	F 609		

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F 609	<p>Continued From page 5</p> <p>stated RN-A notified her at 12:31 a.m. of R2's elopement, at 1:33 a.m. reported a resident death on first floor and then again at 1:43 a.m. regarding death questions. DON indicated she was not notified of R2's bruise to her arm until 6:49 a.m. R2's bruise had the potential to be caused by this event and the physical aggression and the staff to use to provide maximal physical effort to deescalate R2's situation. DON stated staff were expected to notify her as soon as the incident happened however was informed the bruise was not seen earlier.</p> <p>During an interview on 2/14/24 at 5:56 p.m. administrator stated was notified by DON of R2's incident/bruise on arm on 2/6/24 at 6:56 a.m. Administrator stated he believed the bruise to R2's arm occurred when staff assisted R2 to a seated position. Administrator indicated the incident with R2 was not filed with the state because there was no intended neglect or intentional abuse. Administrator indicated NA-A had displayed generalized attitudes but not intentional harm or injury and DON and myself decided together it was not reportable.</p> <p>Facility policy titled Vulnerable Adults, Reporting Maltreatment, LTC (long term care), AL (assisted living), Swing bed - Canby dated 1/11/23, identified the facility was expected to have provided a safe environment to patients, residents, and clients of Sanford Canby Medical Center (SCMC), and consistent guidelines for preventing, identifying, investigating and reporting suspected maltreatment ensure compliance with the Minnesota Statute 626.557, the Vulnerable Adults Act and amendments; Minnesota Statute 245A.65, and federal nursing home regulation 42 CFR 483.12 Freedom from Abuse, Neglect, and</p>	F 609		

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F 609	Continued From page 6 Exploitation. Facility internal reporting of a suspected maltreatment of a vulnerable adult including all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source that may constitute reasonable suspicion of a crime are reported immediately but not later than two hours after the allegation was made, if the event that cause the allegation involve abuse or result in serious bodily injury. The facility must submit the electronically report of the incident to the Minnesota Department of Health (MDH) or South Dakota Department of Human Services (SD DHS), immediately, but no later than 24 hours after the incident's discovery. Definition of abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting physical harm, pain or mental anguish or exploitation. Physical abuse includes hitting, slapping, pinching, kicking, and also includes controlling behavior through corporal punishment (any act causing deliberate physical pain or discomfort in response to some undesired behavior).	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.	F 610		3/18/24

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245433</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/14/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>SYLVAN COURT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>112 ST OLAF AVENUE SOUTH CANBY, MN 56220</b>		
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F 610	<p>Continued From page 7</p> <p>§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:</p> <p>Based on interview and document review the facility failed thoroughly investigate an allegation of staff to resident abuse for 1 of 3 residents (R2) when resident safety upon immediately at the time of the allegation and during the the investigation was not addressed, no additional residents or staff where interviewed and no staff education/training was provided following incidents.</p> <p>Findings include:</p> <p>R2's quarterly Minimum Data Set dated 1/4/24, identified moderately impaired cognition with wandering behavior one to three days out of seven.</p> <p>During an interview on 2/14/24 at 10:00 a.m. NA-B stated came into work and arrived at 2:00 a.m. NA-B indicated around approximately 3:30 a.m. NA-A radioed for assistance on 2nd floor with R2. NA-B went up to 2nd floor to assist and saw NA-A held R2's door shut and R2 yelled let me out while she pulled on the door from inside her room. NA-B requested NA-A remove her hand from the closed door handle and asked R2 let go of door, go to middle of room so she could be assisted. NA-B entered R2's room, calmed her down, and assisted her to the bathroom. NA-B verified R2 was scared, shaking, and asked to</p>	F 610	<p>1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>On or before 2.27.24, reviewed education with RN A and CNA A on reporting of abuse and neglect.</p> <p>Completed educational review on how to investigate alleged resident abuse and neglect with core team members on 2.27.24.</p> <p>Administrator or designee interviewed R2, 1x a week for 3 weeks beginning on 2.14.24 to assess for care related concerns, reports or findings of any abuse and neglect and nothing has been reported. This audit will be continued 2x per month x 3 months. Results will go to QAPI Committee for further recommendations.</p> <p>2.How will other residents, having the potential to be affected by the same deficient practice, be identified?</p> <p>All residents in the facility have the potential to be affected by this practice.</p>	

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F 610	<p>Continued From page 8</p> <p>not be left alone. NA-B stated R2's left arm long sleeve was pushed up a bit and noticed her left lower arm had a dark purple bruise that covered 75% of her arm. NA-B stated R2 said to her "that bitch did that to me, grabbed my arm and squeezed it hard". NA-B stated after she assisted R2 back to bed reported to RN-A approximately 2:15 a.m. all details regarding the incident between R2 and NA-A when she arrived up to 2nd floor and the large bruise she had found on R2's left lower arm R2 asked NA-B not to leave and reassurance was given.</p> <p>During an interview on 2/14/24 at 12:30 p.m. licensed practical nurse (LPN)-B stated at shift change around 6:15 a.m. (4 hours later) she was informed by registered nurse (RN)-A R2 had a ruff night and NA-B had noticed an injury on R2's left forearm. LPN-B stated at approximately 6:30 a.m. along with RN-A went into R2's room and assessed her arm. LPN-B verified a large dark purple bruise with slight swelling was seen on R2's lower left arm. LPN-B completed measurements and immediately called the DON to report the bruise. LPN-B stated R2 was also taking aspirin at that time. LPN-B indicated R2 stated the witch squeezed my arm and this happened in the middle of the night but unable to identify a name.</p> <p>During an interview on 2/16/24 at 9:30 a.m. RN-A stated R2 was usually calm and her confusion had progressed in the past month or so. RN-A stated R2 required assist of two staff to toilet her or one depending on her condition that day. RN-A stated unsure what triggered R2's behaviors the night of the incident, and had never been combative or hard headed prior to this incident. RN-A stated at approximately 2:15 a.m. NA-B</p>	F 610	<p>SW/Designee implemented a focused interview on care related concerns with 15 residents per month that began in February of 2024 and none of these resident's stated concerns that are reportable. These interviews will continue for 3 additional months and then will re-evaluate need for continuation. This audit will be conducted for 3 months and then will re-evaluate need for continuation. Results of the audit will be reported at our monthly QAPI meeting.</p> <p>3.What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur?</p> <p>All staff will receive education on appropriate reporting of abuse and neglect with competency demonstrated by a quiz.</p> <p>4.How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur?</p> <p>DON/Designee, Administrator, or Improvement Advisor will review and investigate 15 incidents per month to determine they are reported in a timely manner and to assure they are investigated and reported as indicated for 3 months beginning on 2.15.24 and then will re-evaluate for need for continuation. Results of the audit will be reported at our monthly QAPI meeting.</p>	

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F 610	<p>Continued From page 9</p> <p>assisted NA-A with R2. NA-B returned to first floor and informed RN-A R2 had something on her left arm that needed to be looked at. RN-A stated she informed NA-B it would be checked later. RN-A stated she waited until 4:00 a.m. and R2 was sleeping, decided not to bother her, and waited until change of shift. RN-A stated around 6:30 a.m. (over 4 hours later) along with LPN-A went in and assessed R2's left arm and found a large purple bruise measured approximately to 10 to 14 centimeters (cm) and 4 cm across, bulging lump on top, and painful. RN-A verified only one call was made to the DON at 12:00 a.m. during the night shift regarding R2 and her change in behavior.</p> <p>RN-A failed to report the alleged abuse, interview R2 and remove potential staff from working with R2 to ensure R2's safety.</p> <p>Facility internal live event documentation dated 2/6/24, identified event type safety/security event and sub event type threatening behavior/verbal assault. R2 sustained bruise. Intervention: monitor to determine possible harm. R2 obtained a large dark purple bruise measuring 14.5 centimeters (cm) x 6.3 cm to left forearm as a result of incident. R2 did state "that witch squeezed my arm". Director of nursing (DON) interviewed both registered nurse (RN) and nursing assistant (NA) on shift with NA noting resident became aggressive punching RN in buttock and stomach. NA reported she grabbed R2's arm to divert the situation but did not intend harm. R2 currently prescribed aspirin and prednisone (steroid) at risk for bruising and fragile skin.</p> <p>R2's progress notes from 2/6/24, through 2/7/24,</p>	F 610		

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F 610	<p>Continued From page 10 identified:</p> <p>-2/6/24 at 12:30 a.m. (notes revised at 9:52 a.m.) R2 was found walking out of her room with rolling table unassisted. R2 stated loudly and insistently she want to go out and sit on that chair and pointed at the chair at nurse's station. Encouraged and assisted R2 back to her room to the wheelchair to be safe and allowed to roam around her room. R2 refused, got furious and punch nurse in right chest and right wide of stomach and tried to head bang nurse's face with hers. R2 roamed around the floor while RN-1 while NA-A toileted another resident, left the floor via elevator, and was found shortly afterwards on first floor. R2 was brought back up to second floor, secured doors by shutting them and kept her closely monitored. R2 was constantly furious and physical to NA-A when kept safe. Director of nursing (DON) notified. Maintenance will be notified in the morning to request for a wander guard, per DON.</p> <p>-2/6/24 at 6:40 a.m. (notes revised at 2:43 p.m.) Night nurse reported to writer there was an injury to R2's left arm from staff/resident altercation during the night. Writer checked arm with night nurse present. Bruise noted measuring 14.5 x 6.3 centimeters (cm), dark purple with slight swelling in the middle. Skin intact and tender to the touch. The resident reported "that witch squeezed my arm". Monitor daily and take weekly measurements. Resident was on aspirin 81 milligram (mg) daily. DON (director of nursing) notified immediately.</p> <p>During an interview on 2/14/24 at 4:45 p.m. director of nursing (DON) stated a thorough internal investigation was completed on the</p>	F 610		

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F 610	<p>Continued From page 11</p> <p>incident date 2/6/24 with R2. DON indicated R2's memory would not have been reliable with her recent change in cognition. DON stated not a 100% guarantee the bruise on R2's arm was caused by grabbing her, she was an elderly 94 year old with cognitive impairments, dementia, and unable to directly make the assumption as to when it happened and/or what caused it. DON also stated the bruise had the potential to be caused by this event when staff utilized maximal physical effort to get R2 to sit down, and desolate the situation. DON stated education should have been provided and situation could have been handled a different way. DON indicated NA-A's personality/mentality was like she would not take any crap from anyone possibly due to lack of showing compassion and unaware of the encouragement that should have been given to the resident.</p> <p>During an interview on 2/14/24 at 5:56 p.m. administrator stated the 2/6/24, incident with R2 there was no intended neglect or intentional abuse. Administrator indicated no patterns had been identified with NA-A had displayed only generalized attitudes but not intentional harm or injury, therefore no additional interviews were completed with staff or residents. Administrator stated seemed as though another staff member tried to get back at another staff and filed a complaint.</p> <p>During a telephone interview on 2/20/24 at 1:00 p.m. NA-A stated worked the night shift on 2/5/24, on second floor. NA-A stated R2 had left second floor on her own via elevator around 12:00 a.m. NA-A stated later during the night R2 pushed bedside table with wheels to doorway of her room, RN-A intervened, and R2 swung at and</p>	F 610		

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F 610	<p>Continued From page 12</p> <p>punched her in the stomach. NA-A stated along with RN-A assisted R2 into her wheelchair, grabbed her left arm, and when R2 sat down into the chair stated you bitch, you bitch. NA-A indicated later during the night shift R2 was calm and pushed herself in wheelchair around the unit, bathroom was offered, and R2 accepted. NA-A stated while in hallway bathroom with R2 her behavior changed quickly, arms were flaring and unaware if she had lashed out. NA-A stated R2 was brought back to her room and started to hit and came at her with wheelchair. NA-A stated it was a little over whelming and very uncomfortable situation. NA-A indicated R2 was placed in her room alone, exited the room, radioed for help, stood outside of room and closed the door. NA-A stated R2 grabbed the door handle and attempted to open the door. NA-A stated she held onto the door handle and held door closed from the outside of R2's room, and unsure if any words were exchanged. NA-A stated was wrong to have held hand on door handle to hold door closed during that time and was not aware you pick and chose your battles. NA-A stated was the first time she had seen R2 respond that way and tried to avoid escalation of the situation NA-A stated felt uncomfortable working on second floor the rest of that night. NA-A indicated had met with human resources, was informed the residents have the right to leave their rooms if they wanted to. NA-A stated she understood she had made the wrong decision, placed her hand on the handle of the door to hold it closed, should have walked away, and allowed R2 to come out of her room.</p> <p>The facility lacked evidence a thorough investigating was completed which included residents and staff interviews about potential abuse or resident cares being provided by staff to</p>	F 610		

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F 610	Continued From page 13 prevent re-occurrence.  Facility policy titled Investigation, Alleged VA (vulnerable adult) Incident dated 5/9/23, identified a consistent and thorough investigation should have been done as quickly as possible after a report to investigate while memories are fresh assures the most accurate, detailed accounts. Interview all staff on duty at the time of the alleged incident, family members, and other residents. Discreetly clarify statements that are different than reported by other observers. Be aware and alert for discrepancies, unusual behavior or performance or communication.	F 610		

Minnesota Department of Health

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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;"><b>NH LICENSING CORRECTION ORDER</b></p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 2/13/24, through 2/14/24, 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.</p> <p>The following complaints were reviewed during</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>03/14/24</b>
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Minnesota Department of Health

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2 000	<p>Continued From page 1</p> <p>the survey: H54339613C (MN100666), H54339614C (MN100667).</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.</p> <p>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.</p>	2 000		