Electronically delivered
March 15, 2021

Administrator
Perham Living
735 Third Street Southwest
Perham, MN 56573

RE: CCN: 245486
Cycle Start Date: March 8, 2021

Dear Administrator:

On March 8, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 June 8, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 8, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 15, 2021

Administrator
Perham Living
735 Third Street Southwest
Perham, MN 56573

Re: State Nursing Home Licensing Orders
Event ID: SFSG11

Dear Administrator:

The above facility was surveyed on March 3, 2021 through March 8, 2021 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 only a suggestion 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:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245486	A. BUILDING _____ B. WING _____	C 03/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERHAM LIVING	**735 THIRD STREET SOUTHWEST PERHAM, MN 56573**

(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 3/3/21, 3/4/21, and 3/8/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be unsubstantiated: H5486019C (MN00070281). H5486021C (MN00068532 and MN00066115). The following complaint was found to be substantiated: H5486020C (MN00069249) and deficiencies cited at F609 and F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations	F 609		4/20/21

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

Electronically Signed | 03/23/2021

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F 609	Continued From page 1 involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the administrator and no later than 2 hours, to the State Agency (SA) an allegation of resident to resident abuse for 1 of 4 residents (R1) who was reviewed for allegations of abuse. Findings include: R1's annual Minimum Data Set (MDS) dated 1/5/21, indicated R1 had diagnoses which included non-traumatic brain dysfunction, dementia, seizure disorder and was severely cognitively impaired. The MDS indicated R1	F 609	Facility will reeducate nursing home staff involved in the incident and report the unreported incident appropriately. The residents directly impacted by this incident are no longer ambulatory and able to interact with each other: one has passed away and the has experienced a significant decline related to her disease progression. All other charts in the nursing home will be reviewed to ensure no further unreported incidents occurred and that any incidents that did occur had investigations completed in a timely manner.	

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F 609	Continued From page 2 required staff supervision for eating, bed mobility, ambulation and required extensive assist of one staff for dressing, toileting, personal hygiene, bathing and was independent with transfers. The MDS further indicated R1 had behavior symptoms directed towards other physically and verbally 1 to 3 days and wandered 4 to 6 days but less than daily. Review of R1's progress notes from 1/7/21, revealed the following: - at 9:11 p.m. R1 was found in R5's room. R5 was upset, stating R1 had hit her with a pillow, slapped her and twisted her arm. R5 was very frightened. When trying to redirect R1, she pulled the blankets off R5's bed and pushed registered nurse (RN)-A and threw the blanket on the floor and walked out of the room. R1 was very angry. Interventions used: redirection and will watch R1 closely. After further review of R1's medical record, there was no documentation of when the SA was notified of the alleged resident to resident abuse. The facility was unable to provide any documentation that the SA had been notified within 2 hours of the resident to resident altercation. On 3/4/21, at 11:37 p.m. RN-A indicated R1 had gone into R5's room, pulled out her pillow, grabbed and slapped R5 and had attempted to pull R5 out of bed. RN-A indicated R5 was clearly upset and told her what had happened when R1 entered her room. RN-A indicated she tried to redirect R1 out of R5's room, but R1 was angry and did not respond to her redirection. RN-A indicated R1 started to shove her and she was able to escort R1 out of R5's room. RN-A stated	F 609	Facility policy will be revised to clarify the role of all nursing home staff in reporting and investigating vulnerable adult incidents. All staff in the nursing home departments will be educated on updated policy, as well as VA reporting and investigation requirements. Managers and supervisors will be provided enhanced education in order to ensure strong understanding and appropriate intervention and guidance at all times. Audit will be completed one time per day for 4 weeks to ensure all vulnerable adult incidents are reported appropriately, then weekly for the following 8 weeks. The audits and the effectiveness of the corrections will be reviewed at QAPI for a minimum of 3 months or until system is proven effective.	

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F 609	Continued From page 3	F 609		

R1 was placed on 15 minute checks after the incident. RN-A indicated the incident happened around 8:30 p.m. or 9:00 p.m. but was not sure of the actual date. RN-A indicated she had reported the incident to the charge nurse that was working that evening and RN-A assumed the charge nurse was going to report the incident to the SA.

On 3/4/21, at 1:17 p.m. RN-C confirmed it had been reported that R1 entered R5's room in the evening and had frightened her. RN-C indicated R1 grabbed R5's arm and was physically touching her. RN-C confirmed the allegation did not get reported to the SA due to R5 being confused and unreliable at the time. RN-C confirmed the allegation of resident to resident abuse occurred and indicated it should have been reported to the SA immediately.

On 3/4/21, at 12:01 p.m. the director of nursing (DON) was notified of the alleged allegation on 1/7/21, and stated she was not aware of the incident. At 2:49 p.m., the DON confirmed the above finding and indicated she had not been notified of the allegation of resident to resident abuse by staff and the allegation had not been reported to the SA. The DON indicated she would have expected staff to notify her and the administrator immediately whenever an allegation of abuse occurred and within 2 hours to the SA.

On 3/4/21, at 4:40 p.m. the administrator confirmed the above findings and indicated she had not been notified immediately when the resident to resident altercation occurred and indicated staff should have contacted her or the DON. The administrator indicated she would expect staff to follow the facility vulnerable adult policy and report any allegations of abuse within 2

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F 609	Continued From page 4 hours to the SA. Review of the facility policy titled, Vulnerable Adult Reporting revised on 10/1/2020, indicated the facility must report any incidents of actual or suspected maltreatment to the Office of Health Facility Complaints (OHFC) immediately upon becoming knowledgeable of the incident. Immediately is interpreted by surveyors with MDH to be as soon as possible, but not later than 2 hours after the allegation is made, if the event that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse or did not result in serious bodily injury.	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	F 610		4/20/21

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F 610	Continued From page 5 by: Based on interview and document review, the facility failed to thoroughly investigate an allegation of resident to resident abuse for 1 of 4 residents (R1) reviewed for allegations of abuse. In addition, the facility failed to report to the State agency (SA) the results of the investigation within 5 working days for 1 of 4 allegations of abuse reviewed. Findings include: R1's annual Minimum Data Set (MDS) dated 1/5/21, indicated R1 had diagnoses which included non-traumatic brain dysfunction, dementia, seizure disorder and was severely cognitively impaired. The MDS indicated R1 required staff supervision for eating, bed mobility, ambulation and required extensive assist of one staff for dressing, toileting, personal hygiene, bathing and was independent with transfers. The MDS further indicated R1 had behavior symptoms directed towards other physically and verbally 1 to 3 days and wandered 4 to 6 days but less than daily. Review of R1's progress notes from 1/7/21, revealed the following: - at 9:11 p.m. R1 was found in R5's room. R5 was upset, stating R1 had hit her with a pillow, slapped her and twisted her arm. R5 was very frightened. When trying to redirect R1, she pulled the blankets off R5's bed and pushed registered nurse (RN)-A and threw the blanket on the floor and walked out of the room. R1 was very angry. Interventions used: redirection and will watch R1 closely. After further review of R1's medical record, there	F 610	Facility will reeducate nursing home staff involved in the incident and report the unreported incident appropriately. The residents directly impacted by this incident are no longer ambulatory and able to interact with each other: one has passed away and the has experienced a significant decline related to her disease progression. All other charts in the nursing home will be reviewed to ensure no further unreported incidents occurred and that any incidents that did occur had investigations completed in a timely manner. Facility policy will be revised to clarify the role of all nursing home staff in reporting and investigating vulnerable adult incidents. All staff in the nursing home departments will be educated on updated policy, as well as VA reporting and investigation requirements. Managers and supervisors will be provided enhanced education in order to ensure strong understanding and appropriate intervention and guidance at all times. Audit will be completed one time per day for 4 weeks to ensure all vulnerable adult incidents are reported appropriately, then weekly for the following 8 weeks. The audits and the effectiveness of the corrections will be reviewed at QAPI for a minimum of 3 months or until system is proven effective.	

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F 610	Continued From page 6	F 610		

was no documentation of when the SA was notified of the alleged resident to resident abuse and when the investigation was submitted to the SA for the alleged incident. The facility was unable to provide any internal investigation in regards to the allegation.

On 3/4/21, at 12:01 p.m. the director of nursing (DON) was notified of the alleged allegation on 1/7/21, and stated she was not aware of the incident. In a follow up interview at 4:40 p.m., the DON indicated she would expect staff to start the investigation and submit the investigation to the SA within 5 days.

On 3/4/21, at 4:40 p.m. the administrator confirmed the above findings and indicated she had not been notified immediately when the resident to resident altercation occurred and indicated staff should have contacted her or the DON. The administrator indicated she would expect staff to follow the facility vulnerable adult policy and to investigate the allegation and submit the investigation to the SA within 5 days.

Review of the facility policy titled, Vulnerable Adult Reporting revised on 10/1/2020, indicated the facility must report any incidents of actual or suspect maltreatment to the Office of Health Facility Complaints (OHFC) immediately upon becoming knowledgeable of the incident. Immediately is interpreted by surveyors with MDH to be as soon as possible, but not later than 2 hours after the allegation is mad, if the event 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 or do not result in serious bodily injury. The policy also indicated staff were to

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F 610	Continued From page 7 make sure the resident was safe, call the administrator as soon as possible, report to OHFC, put intervention into place immediately and begin the investigation by getting written witness statements from staff.	F 610		

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	00438	A. BUILDING: _____ B. WING _____	C 03/08/2021

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2 000	Initial Comments	2 000		

*****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 3/4/21, 3/5/21, and 3/8/21, an abbreviated survey was conducted to determine compliance of state licensure. Your facility was found not to be in compliance with the MN state licensure.

The following complaints were found to be unsubstantiated:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00438	A. BUILDING: _____ B. WING _____	C 03/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERHAM LIVING	735 THIRD STREET SOUTHWEST PERHAM, MN 56573

(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	Continued From page 1 H5486019C (MN00070281). H5486021C (MN00068532 and MN00066115). The following complaint was found to be substantiated: H5486020C (MN00069249) with licensing order issued at 1980. 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 surveyors 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm 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.	2 000		

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2 000	Continued From page 2 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.	2 000		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has	21980		4/20/21

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21980	Continued From page 3 been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report, no later than 2 hours, to the State Agency (SA) an allegation of resident to resident abuse for 1 of 4 residents (R1) who was reviewed for allegations of abuse. Findings include: R1's annual Minimum Data Set (MDS) dated 1/5/21, indicated R1 had diagnoses which included non-traumatic brain dysfunction, dementia, seizure disorder and was severely cognitively impaired. The MDS indicated R1 required staff supervision for eating, bed mobility, ambulation and required extensive assist of one	21980	Facility will reeducate staff involved in the incident and report the unreported incident appropriately. Facility policy will be revised to clarify staff role in reporting and investigating vulnerable adult incidents. All staff will be educated on updated policy, as well as VA reporting and investigation requirements. Audit will be completed one time per day for 4 weeks to ensure all vulnerable adult incidents are reported appropriately. The	

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21980	Continued From page 4 staff for dressing, toileting, personal hygiene, bathing and was independent with transfers. The MDS further indicated R1 had behavior symptoms directed towards other physically and verbally 1 to 3 days and wandered 4 to 6 days but less than daily. Review of R1's progress notes from 1/7/21, revealed the following: - at 9:11 p.m. R1 was found in R5's room. R5 was upset, stating R1 had hit her with a pillow, slapped her and twisted her arm. R5 was very frightened. When trying to redirect R1, she pulled the blankets off R5's bed and pushed registered nurse (RN)-A and threw the blanket on the floor and walked out of the room. R1 was very angry. Interventions used: redirection and will watch R1 closely. After further review of R1's medical record, there was no documentation of when the SA was notified of the alleged resident to resident abuse. The facility was unable to provide any documentation that the SA had been notified within 2 hours of the resident to resident altercation. On 3/4/21, at 11:37 p.m. RN-A indicated R1 had gone into R5's room, pulled out her pillow, grabbed and slapped R5 and had attempted to pull R5 out of bed. RN-A indicated R5 was clearly upset and told her what had happened when R1 entered her room. RN-A indicated she tried to redirect R1 out of R5's room, but R1 was angry and did not respond to her redirection. RN-A indicated R1 started to shove her and she was able to escort R1 out of R5's room. RN-A stated R1 was placed on 15 minute checks after the incident. RN-A indicated the incident happened around 8:30 p.m. or 9:00 p.m. but was not sure of	21980	audits and the effectiveness of the corrections will be reviewed at QAPI.	

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21980	Continued From page 5	21980		

the actual date. RN-A indicated she had reported the incident to the charge nurse that was working that evening and RN-A assumed the charge nurse was going to report the incident to the SA.

On 3/4/21, at 1:17 p.m. RN-C confirmed it had been reported that R1 entered R5's room in the evening and had frightened her. RN-C indicated R1 grabbed R5's arm and was physically touching her. RN-C confirmed the allegation did not get reported to the SA due to R5 being confused and unreliable at the time. RN-C confirmed the allegation of resident to resident abuse occurred and indicated it should have been reported to the SA immediately.

On 3/4/21, at 12:01 p.m. the director of nursing (DON) was notified of the alleged allegation on 1/7/21, and stated she was not aware of the incident. At 2:49 p.m., the DON confirmed the above finding and indicated she had not been notified of the allegation of resident to resident abuse by staff and the allegation had not been reported to the SA. The DON indicated she would have expected staff to notify her and the administrator immediately whenever an allegation of abuse occurred and within 2 hours to the SA.

On 3/4/21, at 4:40 p.m. the administrator confirmed the above findings and indicated she had not been notified immediately when the resident to resident altercation occurred and indicated staff should have contacted her or the DON. The administrator indicated she would expect staff to follow the facility vulnerable adult policy and report any allegations of abuse within 2 hours to the SA.

Review of the facility policy titled, Vulnerable Adult Reporting revised on 10/1/2020, indicated the

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21980	Continued From page 6 facility must report any incidents of actual or suspected maltreatment to the Office of Health Facility Complaints (OHFC) immediately upon becoming knowledgeable of the incident. Immediately is interpreted by surveyors with MDH to be as soon as possible, but not later than 2 hours after the allegation is made, if the event that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse or did not result in serious bodily injury. Suggested Method of Correction: The administrator and/or designee could review the facility polices in regards to reporting of allegations of abuse to the State Agency. The administrator and/or designee could educate staff on ensuring reports are submitted in a timely manner. The administrator or designee could routinely monitor to ensure reports are submitted in a timely manner. Suggested Date of Correction: Fourteen (14) days	21980		