DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 30, 2023

Administrator
Oak Hills Living Center
1314 Eighth Street North
New Ulm, MN 56073

RE: CCN: 245490
Cycle Start Date: May 18, 2023

Dear Administrator:

On May 18, 2023, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On May 5, 2023, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

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 listed below to the CMS Region V Office forimposition: You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered

professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 18, 2023. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.</u>

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Oak Hills Living Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 18, 2023. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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:

Nathan Schreier, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: nate.schreier@state.mn.us
Office: (651) 201-4348 Mobile (651) 392-2726

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) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions

are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245490	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILLS LIVING CENTER	1314 EIGHTH STREET NORTH NEW ULM, MN 56073

(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 5/17/23 to 5/18/23, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed: H54902232C (MN93324) and a deficiency was issued at (F689) at PAST NON-COMPLIANCE. The following complaint was reviewed with no deficiencies cited: H54902302C (MN87936). Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F 000	Past noncompliance: no plan of correction required.	
F 689 SS=J	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 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review, the facility failed to provide adequate supervision for 1 of 1 residents (R1) who despite being at risk for elopement and wearing an	F 689	Past noncompliance: no plan of correction required.	

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

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 689	Continued From page 1	F 689		

elopement security band, left the facility unsupervised and without staff knowledge. This resulted in immediate jeopardy when R1 walked 218 yards across uneven terrain into a parking lot of a neighboring apartment complex placing him at risk for serious harm, impairment, or death.

The immediate jeopardy began on 5/4/23 at 3:25 p.m., when R1 left the facility unsupervised and was identified on 5/4/23 at 3:55 p.m., when the facility was notified by a tenant at the neighboring apartment complex and the facility arrived to pick up R1. The administrator, director of nursing (DON) and social worker (SW)-A were notified of the immediate jeopardy on 5/18/23 at 11:19 a.m. The facility immediately implemented corrective action and was corrected on 5/5/23 prior to the survey and was issued at Past Noncompliance.

Findings include:

R1's facesheet printed on 5/17/23, indicated diagnoses of dementia, weakness, unsteadiness of feet and repeated falls.

R1's quarterly Minimum Data Set (MDS) assessment dated 5/3/23, indicated R1 had moderately impaired cognition, adequate vision and hearing, clear speech, was usually understood and was usually able to understand. R1 required assistance of one staff for transferring between surfaces, walking in his room and around the unit. R1 required extensive assistance of one staff when walking off the unit and used a wander/elopement alarm daily.

R1's admission care plan dated 12/30/22, indicated R1 was at high risk for falls. Care plan

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F 689	Continued From page 2 dated 1/23/23, indicated R1 had cognitive loss with confusion and impaired decision making with a history of elopement, wandering and exit seeking behaviors. Care plan dated 1/30/23, indicated R1 was at high risk for elopement and would be supervised at all times when outside, and a security alarm bracelet or other sensor system to reduce risk of elopement from facility. R1's physician order dated 1/24/23, and again on 3/10/23, indicated: Wanderguard (WG) - Check to ensure functioning properly every day and PRN (as needed). Elopement risk assessments upon admission on 12/30/22, and on 2/3/23, indicated R1 scored a 12/20 points, which identified he was at risk for elopement. After the elopement incident on 5/4/23, an elopement risk assessment was completed indicating R1 was at risk, scoring 20/20 points. The maximum score was 25, indicating the highest elopement risk. A fall risk assessment dated 5/3/23, indicated R1 scored 21, indicating high fall risk. The fall risk assessment identified he had eight falls in 2023. R1's treatment administration record (TAR) indicated R1's WG was checked daily by staff starting 1/25/23 through 5/17/23, apart from 3/1/23, when R1 was in the hospital. A progress noted dated 5/4/23 at 4:17 p.m., indicated the facility had been alerted R1 had been outside sitting in front of the next-door apartment complex. Registered nurse (RN)-A and the DON immediately left the facility and went to the apartment building. R1 was found safe and stated he had not fallen and was just sitting	F 689		

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F 689	Continued From page 3 enjoying the nice weather. R1 was returned to the facility via facility bus. RN-A and the DON verified R1's WG bracelet was on, however it did not activate the security alarm when R1 was brought back into the facility. A new WG was applied and verified to be in working order. As an intervention to future elopement, RN-A spoke to family member (FM)-C about taking R1 all the way to his room when family and friends brought him back to the facility. During an observation on 5/17/23 at 10:45 a.m., together with SW-A, walked the route R1 took on 5/4/23 when he left the facility with his four-wheeled walker. R1 walked on a paved walking path next to the facility, then across approximately eight feet of a gravel service road used by facility maintence staff, then a distance on sloping grass, then between large decorative rocks to a paved parking lot utilized by tenants and visitors of the apartment complex to a bench at the main entrance of the apartment complex. During an interview on 5/17/23 at 11:23 a.m., maintenance supervisor (MS)-A measured the distance R1 walked with a measuring wheel and reported the distance as 655 feet (218 yards) from the facility entrance to the bench where he was found. During an interview and observation on 5/17/23 at 11:23 p.m., receptionist (R)-D stated she had been working the day R1 left the facility unsupervised. R-D stated R1 had just come back from playing cards at about 3:25 p.m. R1's friend (F)-E walked R1 into the facility and R-D told R1 to have a seat and she would call the nursing unit and have someone escort him back to the second floor. R1 took a seat on a chair in front of	F 689		

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F 689	Continued From page 4 door, which was approximately five or six feet directly in front of the automatic sliding glass doors. R-D stated she had been printing checks from her reception desk to a printer in an office behind the reception desk and had been going back and forth between the reception desk and the office to retrieve the checks. According to MS-A on 5/17/23 at 11:41 p.m., the measured distance from the reception desk to the printer was 59 feet. R1 was not visible from the office with the printer. R-D estimated R1 had been out of her sight for about four minutes. When R-D noticed R1 was gone, she assumed nursing staff had picked up R1 to escort him back to his room. At about 3:45 p.m., R-D received a telephone call from someone who recognized R1 and informed the facility he was sitting outside at the neighboring apartment complex. R-D immediately called the nurses station and told them R1 was next door, then called RN-A to inform her. During an interview on 5/17/23 at 12:29 p.m., RN-A stated she had been working the day R1 eloped. RN-A had received a call from R-D at the front desk who informed her R1 was at the neighboring apartment complex. RN-A and the DON immediately went to the apartment complex and found R1 sitting on a bench. When asked what he was doing, R1 stated he was enjoying the day. RN-A stated R1 denied falling and had no apparent injuries. R1 was returned to the facility via the facility bus. On their way back to the facility, RN-A stated both she and the DON wondered if the WG would alarm when they returned to the facility. When R1 went through the entrance door, the alarm did not sound. RN-A confirmed when a resident had a properly functioning WG, a door alarm would activate whether entering or exiting the door. When R1	F 689		

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F 689	Continued From page 5 was returned to the facility a new WG was applied right away. RN-A stated when licensed practical nurse (LPN)-A applied the new WG on 5/4/23, she told RN-A she had to "activate it." RN-A stated, "That queued us to this [activate] step" which may have identified the reason R1 was able to leave the facility without an alarm sounding. RN-A stated R1's first elopement attempt was on 1/24/23 when he had been looking for the elevator and front door multiple times; as a result, a WG was applied on 1/24/23. RN-A was unsure if R1's WG had been activated when applied on 1/24/23. During an interview on 5/17/23 at 12:48 p.m., SW-A stated she had been working the day R1 eloped. Following the incident, she looked at the display phones to determine the sequence of events and stated R1 was unaccounted for for about 20 minutes. The display phone indicated the following: --3:25 p.m., R-D called the nursing unit to escort R1 to his room. --3:45 p.m., R-D received call from apartment complex alerting the facility of R1's whereabouts. --3:48 p.m., R-D called RN-A to notify her of the phone call she received about R1's whereabouts. SW-A stated RN-A and the DON reached R1 at the apartment complex at 3:55 p.m. During a telephone interview on 5/17/23 at 1:30 p.m., F-E stated he was a friend of R1's and had picked up R1 on 5/4/23 between 12:30 p.m. and 1 p.m. to play cards. F-E stated he dropped R1 off at 3 p.m. in the lobby. R1 told F-E he didn't want F-E to walk him to his room. During an interview on 5/17/23 at 2:29 p.m., the DON stated she had been working the day R1	F 689		

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F 689	Continued From page 6 eloped. She was notified immediately when the facility learned R1 was at the neighboring apartment complex. She went with RN-A to assess R1 and return him to the facility. When they returned to the facility, the DON stated R1's WG did not activate the alarm when they brought him through the main entrance door. The DON began their investigation right away by interviewing staff, notifying R1's family and the nurse practitioner (NP). She stated a new WG had been applied to R1 upon return to the facility and staff ensured it was working. The DON stated when a WG was initially activated, the hand-held detector sounded a beep to verify activation. Following the activation step, staff conducted daily checks to ensure proper WG function. The DON stated to do this, staff placed a hand-held detector next to a WG tag and were to visualize two small green lights illuminated on the detector. One green light indicated battery strength and the other verified activation. The DON stated through their investigation, they determined R1's WG had not been activated when applied on 1/24/23. When staff tested R1's WG each day, only one green light illuminated indicating battery strength. According to the DON, staff conducting the daily testing did not know that two green lights needed to illuminate on the detector to ensure proper functioning. According to the DON, following the incident on 5/4/23, the following corrective actions were taken: -- An audit was conducted to ensure two green lights illuminated on the detector for each of the 13 other residents with a WG. No concerns were identified. --1:1 RN, LPN and TMA re-education was initiated on 5/4/23. --Computer desk-top education was added. --Re-education occurred again at a staff meeting	F 689		

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F 689	Continued From page 7 on 5/10/23 about ensuring two green lights were present when monitoring WG bands. --The WG instructions were simplified and illustrations added to enhance staff understanding. --Verbiage was added to the TAR for each resident with a WG to check the WG with the detector once daily and ensure two green lights were visible. --Added to a new employee's 14-day check-in meeting, was verify the new employee's understanding of activating and testing WG's. --A new WG policy as created. --WG audits would commence for three months. The DON explained the discrepancy regarding the time F-E stated he returned R1 to the facility on 5/4/23 (F-E stated 3:00 p.m. and interviews specified this time to be 3:25 p.m.). The DON stated according to the paper sign-out log, F-E prefilled the sign-in time on the log with 3:00 p.m. when he picked up R1 between 12:30 p.m. and 1:00 p.m. The sign-in/sign-out sheet was located on the second floor and F-E self-admitted he did not escort R1 back to his room when returning to the facility on 5/4/23 and therefore could not have signed R1 back in. During an interview on 5/17/23 at 3:01 p.m., (LPN)-B stated when R1 went to the hospital on 2/28/23, R1's WG bracelet had been removed and locked in a cupboard in his room. When he returned on 3/2/23, LPN-B obtained the WG from the cupboard, reapplied it, tested it and stated she recalled seeing two green lights illuminate on the detector. RN-A had not been aware R1's WG had been removed and reapplied before and after hospitalization. RN-A stated regardless, the WG should have been activated on 1/24/23, so would	F 689		

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F 689	Continued From page 8 not have needed to be activated again on 3/2/23. Manufacturer instructions provided by the DON titled WanderGuard Blue v1.4 - Quick Reference Guide (undated) indicated the following: --ACTIVATING a tag with the detector: 1. Turn on WanderGuard BLUE detector by short-pressing the power button when out of the controller LF (low frequency) range. 2. Place a WanderGuard BLUE tag within the detector's LF range - 12 inches. 3. Activate the tag - press the power button for 1.5 seconds. Detector sends an activation message via LF. It beeps to indicate it is sending an activation message. 4. Upon receiving BLE (Bluetooth low energy) message from the tag, the detectors LF LED (light emitting diode) lights green for two seconds. --CHECKING the tag battery level: 1. Turn on WanderGuard BLUE detector by short-pressing the power button. 2. Place the tag within the LF range of the detector (less than 12 inches). The detector constantly sends LF messages. 3. The detector displays the tag battery level by flashing the tag battery LED and LF LED for two seconds after receiving the BLE message from the tag. 4. When the detector is in proximity to an activated tag, the LED's continue to display green or red depending on the battery level. During a phone interview on 5/17/23 at 3:59 p.m., FM-C stated he had been informed of R1's elopement right away on 5/4/23. FM-C stated R1 had a mind of his own and was determined to do what he wanted. FM-C stated he had picked up R1 for church recently and, "Now the bells go off."	F 689		

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	245490	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 9 FM-C did not recall if alarms went off prior to this, stating, "I think so, but I can't say for sure." During an interview on 5/17/23 at 5:30 p.m., the DON stated through their investigation, it was concluded R1's WG had not been activated when applied on 1/24/23. The DON did not know how staff had been testing R1's WG daily and documenting proper functioning since 1/24/23 when he was in the facility. when not visualizing two green lights on the detector. The DON stated their previous WG system illuminated with one light indicating proper functioning and thought some staff recalled the old system when conducting testing on current WG's. According to an undated document titled staff interviews conducted by SW-A during the facility investigation, LPN-B reported she had never received education on WG's and checking the batteries. (LPN)-A reported she had never been given education about how to activate or properly check the WG pendants; had only been checking battery life and didn't know to also be checking LF Beacon light to ensure activation. During an interview on 5/18/23 at 10:29 a.m., office employee (OE)-F whose office was located next to the reception desk, stated through a window, she observed R1 leave with F-E on 5/4/23. OE-F stated she watched R1 get into the car and did not hear the WG alarm go off when he left the building, adding she never heard the alarm go off for R1. OE-F stated at the time, she didn't know R1 wore a WG. OE-F stated that was going to change now, as reception and office staff were going to get a list indicating which residents wore a WG's.	F 689		

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F 689	Continued From page 10 During an observation on 5/18/23 from 1:13 p.m. to 1:18 p.m., observed (TMA)-A test WG's for the following residents: R1, R2, R3 and R4. TMA-A demonstrated how the detector was used to test WG's and verbalized two green lights need to been seen. Two green lights illuminated as TMA-A tested WG's for each resident. New policy (according to the DON) titled Wanderguard's - Protocol and Policy, undated, indicated wanderguard's were used for residents at risk of elopement. To obtain a wanderguard, the resident must be care-planned for one. Wandergaurds were dated when activated. Log sheets were filled out with resident information, serial number, and date of activation. Wanderguard bracelets were checked daily on the evening shift primarily by TMA's or nurses and documented in the electronic medical record. Wandergaurds were not removed unless a resident was transferred out of the facility. Facility policy titled Safety and Supervision of Residents, reviewed on 1/23/23, indicated the facility strived to make the environment as free from accident hazards as possible. Resident safety and supervision to prevent accidents were facility-wide priorities. Safety risks and environmental hazards were identified on an on-going basis through employee training, employee monitoring and reporting processes. Due to their complexity and scope, certain resident risk factors and environmental hazards were addressed in dedicated policies and procedures. Included in the identified risk factors was unsafe wandering.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 30, 2023

Administrator
Oak Hills Living Center
1314 Eighth Street North
New Ulm, MN 56073

Re: Event ID: BXWN11

Dear Administrator:

The above facility survey was completed on May 18, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00041	A. BUILDING: _____ B. WING _____	C 05/18/2023

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/17/23 to 5/18/23 a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was in compliance with the MN State Licensure. The following complaint was reviewed with no	2 000		

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2 000	Continued From page 1 deficiency issued: H54902302C (MN87936). The following complaint was reviewed: H54902232C (MN93324) and a deficiency was issued at (F689) for past none compliance but no correction is required. 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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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		