DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 9, 2021

Administrator
Augustana Mercy Care Center
710 South Kenwood Avenue
Moose Lake, MN 55767

RE: CCN: 245491
Cycle Start Date: March 8, 2021

Dear Administrator:

On April 9, 2021, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

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

Electronically delivered
March 18, 2021

Administrator
Augustana Mercy Care Center
710 South Kenwood Avenue
Moose Lake, MN 55767

RE: CCN: 245491
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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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:

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245491	A. BUILDING _____ B. WING _____	C 03/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA MERCY CARE CENTER	**710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767**

(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, through 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 SUBSTANTIATED: H5491042C (MN57356) with no deficiency due to corrective actions taken by the facility. H5491043C (MN57834) with no deficiency due to corrective actions taken by the facility. H5491044C (MN58221) with no deficiency due to corrective actions taken by the facility. H5491045C (MN58229) with no deficiency due to corrective actions taken by the facility. H5491046C (MN60014) with no deficiency due to corrective actions taken by the facility. H5491047C (MN65357) with no deficiency due to corrective actions taken by the facility. H5491048C (MN68735) with no deficiency due to corrective actions taken by the facility. H5491049C (MN70386) with no deficiency due to corrective actions taken by the facility. However, a related deficiency was identified. 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.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/25/2021

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 000	Continued From page 1 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=E	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 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	F 609		3/25/21

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F 609	Continued From page 2 by: Based on interview and document review, the facility failed to ensure allegations of abuse were reported immediately (within two hours) to the administrator and State Agency (SA) for 4 of 8 residents (R4, R5, R6, and R7) reviewed for abuse. Findings include: R4's Face Sheet printed on 3/8/21, indicated R4's diagnoses included dementia without behavioral disturbance. R4's significant change Minimum Data Set (MDS) dated 6/19/20, indicated R4 had a memory problem. A facility incident report submitted to the SA on 1/26/21 at 3:03 p.m., indicated on 1/25/20, at 8:30 p.m. licensed practical nurse (LPN)-A argued with R4 and reportedly said, "I am not calling the fricking doctor for you." R5's Face Sheet printed on 3/8/21, indicated R5's diagnoses included Alzheimer's disease. R5's significant change MDS dated 4/2/20, indicated R5 had memory problems, and refused to answer questions. A facility incident report submitted to the SA on 2/15/20, at 3:12 p.m. indicated R5 struck R6 in the left upper arm on 2/14/20, at 2:00 p.m. R6's Face Sheet printed on 4/8/21, indicated R6's diagnoses included dementia with behavioral disturbance, psychotic disorder with hallucinations, and delusional disorders.	F 609	F609 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Cassia (Augustana Mercy Care Center LLC. doing business as Moose Lake Village) to comply with F609. To assure continued compliance, the following plan has been put into place; Regarding cited residents: The facility was cited based on the facility failed to ensure allegations of abuse were reported immediately (within two hours) to the administrator and State Agency (SA) for 4 of 8 residents (R4, R5, R6 & R7) reviewed for abuse. Actions taken to identify other potential residents having similar occurrences: Audit completed of all reportable events/incidents in the past 90 days conducted to ensure that they were reported in the required timeframe. No additional concerns found during audit of four records filed for alleged reports of abuse conducted on 3/25/2021. Measures put in place to ensure deficient practice does not recur: All facility staff were re-educated on the importance of reporting concerns of alleged abuse to the appropriate parties immediately (within two hours) as well as	

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F 609	Continued From page 3 R6's quarterly MDS dated 2/11/21, indicated R6 was rarely understood and was rarely able to understand others. A facility incident report submitted to the SA on 2/15/20, at 3:12 p.m. indicated R6 was struck in the left upper arm by R5 on 2/14/20, at 2:00 p.m. R7's Face Sheet printed on 3/8/21, indicated R7's diagnoses included dementia with behavioral disturbance. R7's quarterly MDS dated 9/10/20, indicated R7 sometimes was understood and sometimes able to understand. A facility incident report submitted to the SA on 4/8/20, at 10:41 a.m. indicated R7 was reported to have grabbed and scratched other residents on 4/5/20, at 7:00 p.m. On 3/5/21, at 10:08 a.m. registered nurse (RN)-A was interviewed. RN-A she received training on abuse at least annually, and verified staff to resident verbal abuse should be reported immediately. RN-A verified resident to resident abuse should also be reported immediately. -at 10:26 a.m. NA-A was interviewed. NA-A verified she received training on abuse and abuse reporting at least annually, and was aware that staff to resident abuse or resident to resident abuse needed to be reported immediately. -at 10:45 a.m. trained medication aide (TMA)-A was interviewed. TMA-A verified she received training on abuse at least annually. TMA-A verified resident to resident abuse needs to be	F 609	a general course assigned through Relias (facility education module) regarding reporting alleged reports of abuse. Education assigned for the completion date of April 6th, 2021 through Relias education modules. Re-education via educational signing acknowledgement with departmental education provided on dates: 3/24-3/29/2021. Effective implementation of actions will be monitored by: The Director of Nursing, or designee will audit all reportable events/incidents for the next 90 days to ensure that all reports are filed with the appropriate parties within the required timeframe. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Director of Nursing, or designee is responsible for maintain compliance. Completion date for certification purposes only is: April 6, 2021	

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F 609	Continued From page 4 reported immediately. On 3/8/21, at 11:46 a.m. the director of nursing (DON) was interviewed. The DON verified staff to resident abuse or resident to resident abuse needs to be reported immediately (within two hours). The DON stated she would expect staff would report the abuse to the RN, the DON, or administrator immediately. The facility policy Vulnerable Adult-MN dated 10/31/19, directed staff to report all suspected/alleged violations immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involved abuse.	F 609		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 18, 2021

Administrator
Augustana Mercy Care Center
710 South Kenwood Avenue
Moose Lake, MN 55767

Re: State Nursing Home Licensing Orders
Event ID: HGZ611

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:

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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
	00049	A. BUILDING: _____ B. WING _____	C 03/08/2021

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AUGUSTANA MERCY CARE CENTER	**710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767**

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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 3/3/21, through 3/8/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000	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	

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5491042C (MN57356) no licensing orders were issued due to actions taken by the facility. H5491043C (MN57834) no licensing orders were issued due to actions taken by the facility. H5491044C (MN58221) no licensing orders were issued due to actions taken by the facility. H5491045C (MN58229) no licensing orders were issued due to actions taken by the facility. H5491046C (MN60014) no licensing orders were issued due to actions taken by the facility. H5491047C (MN65357) no licensing orders were issued due to actions taken by the facility. H5491048C (MN68735) no licensing orders were issued due to actions taken by the facility. H5491049C (MN70386) no licensing orders were issued due to actions taken by the facility. However, a related licensing order was issued at S1980. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000	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. 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	

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2 000	Continued From page 2	2 000	VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
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 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	21980		3/25/21

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	00049	A. BUILDING: _____ B. WING _____	C 03/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA MERCY CARE CENTER	710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767

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21980	Continued From page 3 (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 ensure allegations of abuse were reported immediately (within two hours) to the administrator and State Agency (SA) for 4 of 8 residents (R4, R5, R6, and R7) reviewed for abuse. Findings include: R4's Face Sheet printed on 3/8/21, indicated R4's diagnoses included dementia without behavioral disturbance. R4's significant change Minimum Data Set (MDS) dated 6/19/20, indicated R4 had a memory problem. A facility incident report submitted to the SA on 1/26/21 at 3:03 p.m., indicated on 1/25/20, at 8:30 p.m. licensed practical nurse (LPN)-A argued with R4 and reportedly said, "I am not calling the fricking doctor for you."	21980	F609 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Cassia (Augustana Mercy Care Center LLC. doing business as Moose Lake Village) to comply with F609. To assure continued compliance, the following plan has been put into place; Regarding cited residents: The facility was cited based on the facility failed to ensure allegations of abuse were reported immediately (within two hours) to the administrator and State Agency (SA) for 4 of 8 residents (R4, R5, R6 & R7) reviewed for abuse.	

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21980	Continued From page 4 R5's Face Sheet printed on 3/8/21, indicated R5's diagnoses included Alzheimer's disease. R5's significant change MDS dated 4/2/20, indicated R5 had memory problems, and refused to answer questions. A facility incident report submitted to the SA on 2/15/20, at 3:12 p.m. indicated R5 struck R6 in the left upper arm on 2/14/20, at 2:00 p.m. R6's Face Sheet printed on 4/8/21, indicated R6's diagnoses included dementia with behavioral disturbance, psychotic disorder with hallucinations, and delusional disorders. R6's quarterly MDS dated 2/11/21, indicated R6 was rarely understood and was rarely able to understand others. A facility incident report submitted to the SA on 2/15/20, at 3:12 p.m. indicated R6 was struck in the left upper arm by R5 on 2/14/20, at 2:00 p.m. R7's Face Sheet printed on 3/8/21, indicated R7's diagnoses included dementia with behavioral disturbance. R7's quarterly MDS dated 9/10/20, indicated R7 sometimes was understood and sometimes able to understand. A facility incident report submitted to the SA on 4/8/20, at 10:41 a.m. indicated R7 was reported to have grabbed and scratched other residents on 4/5/20, at 7:00 p.m. On 3/5/21, at 10:08 a.m. registered nurse (RN)-A was interviewed. RN-A she received training on	21980	Actions taken to identify other potential residents having similar occurrences: Audit completed of all reportable events/incidents in the past 90 days conducted to ensure that they were reported in the required timeframe. No additional concerns found during audit of four records filed for alleged reports of abuse conducted on 3/25/2021. Measures put in place to ensure deficient practice does not recur: All facility staff were re-educated on the importance of reporting concerns of alleged abuse to the appropriate parties immediately (within two hours) as well as a general course assigned through Relias (facility education module) regarding reporting alleged reports of abuse. Education assigned for the completion date of April 6th, 2021 through Relias education modules. Re-education via educational signing acknowledgement with departmental education provided on dates: 3/24-3/29/2021. Effective implementation of actions will be monitored by: The Director of Nursing, or designee will audit all reportable events/incidents for the next 90 days to ensure that all reports are filed with the appropriate parties within the required timeframe. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Director of Nursing, or designee is responsible for maintain compliance. Completion date for certification purposes	

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21980	Continued From page 5 abuse at least annually, and verified staff to resident verbal abuse should be reported immediately. RN-A verified resident to resident abuse should also be reported immediately. -at 10:26 a.m. NA-A was interviewed. NA-A verified she received training on abuse and abuse reporting at least annually, and was aware that staff to resident abuse or resident to resident abuse needed to be reported immediately. -at 10:45 a.m. trained medication aide (TMA)-A was interviewed. TMA-A verified she received training on abuse at least annually. TMA-A verified resident to resident abuse needs to be reported immediately. On 3/8/21, at 11:46 a.m. the director of nursing (DON) was interviewed. The DON verified staff to resident abuse or resident to resident abuse needs to be reported immediately (within two hours). The DON stated she would expect staff would report the abuse to the RN, the DON, or administrator immediately. The facility policy Vulnerable Adult-MN dated 10/31/19, directed staff to report all suspected/alleged violations immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involved abuse. SUGGESTED METHOD OF CORRECTION: The Administrator, Social Services Director, Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure immediate reporting of abuse allegations. The Administrator, Social Services Director, Director of Nursing or designee could educate all	21980	only is: April 6, 2021	

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21980	Continued From page 6 appropriate staff on the policies and procedures. The Administrator, Social Services Director, Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21980		