DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 18, 2022

Administrator
Moose Lake Village
710 South Kenwood Avenue
Moose Lake, MN 55767

RE: CCN: 245491
Cycle Start Date: December 1, 2021

Dear Administrator:

On January 14, 2022, we notified you a remedy was imposed. On February 8, 2022 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 7, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 13, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 8, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 13, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 7, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
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
December 8, 2021

Administrator
Moose Lake Village
710 South Kenwood Avenue
Moose Lake, MN 55767

RE: CCN: 245491
Cycle Start Date: December 1, 2021

Dear Administrator:

On December 1, 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:

Terri Ament, Rapid Response
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 March 1, 2022 (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 June 1, 2022 (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
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 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE	**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 12/1/21, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to be not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5491058C (MN78985), with deficiencies cited at F600 and F609. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed ensure residents were free from	F 600	F600 This Plan of Correction constitutes my	1/6/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/17/2021

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 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE	**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 600	Continued From page 1 verbal abuse for 1 of 3 residents (R1) reviewed for verbal abuse. Findings Include: R1's Face Sheet printed 12/1/21, indicated R1's diagnoses included left femur fracture, finger fracture, unsteadiness, dementia with behavioral disturbances, cognitive impairment and urinary tract infection (UTI). R1's admission Minimum Data Set (MDS) dated 10/24/21, indicated R1 had mildly impaired cognition and had verbal behaviors directed at others. The MDS further indicated R1 required assistance of staff with all activities of daily living (ADLs) except for eating. R1's care plan dated 10/22/21, indicated R1 had a history of expressing self with yelling out for help, frequently requesting assistance, changing her request to the opposite of the previous request and using profanity to insult staff when she was frustrated. R1's hearing was adequate. A Facility Reported Incident (FRI) submitted to the State Agency (SA) on 11/29/21, at 1:52 p.m. identified allegations of emotional or mental abuse towards R1 which occurred on 11/27/21, at 5:00 p.m. The description included the incident was reported to the administrator and the director of nursing (DON) on 11/29/21, by nursing assistant (NA)-B. NA-B reported NA-A had made statements of, "Stop yelling, I'm going to shut your door if you don't shut up" to R1. NA-B reported NA-A was also mocking R1's statements of, "Help me." Action taken to protect the resident included NA-A was suspended pending the internal investigation.	F 600	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 policy of Cassia (Moose Lake Village b.d.a. Augustana Mercy Health Care Center) to comply with F600 To assure continued compliance, the following plan has been put into place; Regarding cited residents: The facility failed to ensure residents were free from verbal abuse for 1 of 3 residents (R1) reviewed for verbal abuse. Action taken to identify other potential residents having similar occurrences: All interview-able potentially affected residents' interviews were conducted to ensure that no further reports of alleged verbal abuse were noted. No further reports of verbal abuse were found during facility resident interviews. Measures put into place to ensure deficient practice does not recur: Staff for the facility including all departments (whole-house) were re-educated via verbal read and sign documentation on resident rights including, but not limited to Vulnerable Adult reporting and allegations of reported abuse starting on 12/1/2021 and 12/6/2021; will be completed by 1/6/2021. Further, staff will be re-educated via mandatory in-person meeting on what qualifies as abuse and the importance of reporting suspected or alleged reports of	

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 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE	**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 600	Continued From page 2 On 12/1/21, at 12:42 p.m. R1's family member (FM)-A was interviewed. FM-A stated he was was notified of the alleged verbal abuse. FM-A stated R1 had been calling out for help since prior to admission, her calls for help were not that loud, but could be louder now now due to a recent UTI. FM-A stated he did not know if R1 intentionally yelled out as R1 had dementia. FM-A stated R1 probably would have heard NA-A telling her to shut up, and stated R1 would have been upset. FM-A stated R1 had dementia, but her senses weren't gone. On 12/1/21, at 2:04 p.m. NA-B was interviewed and stated she worked with NA-A on Saturday, 11/27/21, on the afternoon shift. NA-B stated this was the first time she had worked with NA-A as her partner. NA-B stated she observed NA-A say to R1, "Shut up or I'm going to shut her door." NA-B stated NA-A yelled this from R1's doorway. NA-B stated NA-A was also mocking R1 saying, "Help, Help, shut up [R1]." NA-B stated she did not see R1's response, but R1 would get quiet, and then return to yelling. NA-B stated NA-A said these statements at least three times during a short period of time after dinner. NA-B stated R1 yelled out help quite consistently, even when they were helping her. Hearing NA-A's statements to R1 bothered NA-B, but NA-B did not do anything and knew it was wrong. NA-B stated she did not report the incident until Monday 11/29/21, as she felt there was tension between the other staff. NA-B further stated TMA-A and LPN-A were also present when NA-A was mocking R1 and telling R1 to shut up. NA-B waited and reported the incident because she was afraid of retaliation. On 12/1/21, at 2:45 p.m. NA-A was interviewed.	F 600	abuse in an appropriate timeframe by 1/6/2022. Effective implementation of actions will be monitored by: The facility leadership, or designee(s) will audit through [(three) staff and (six) resident] interviews randomly, monthly for the next 90 days to ensure verbal and other abuse does not occur. 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: January 6, 2022.	

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 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE	**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 600	Continued From page 3 NA-A denied telling R1 to shut up or I'll shut the door, and denied mocking R1. NA-A stated she did not know who would report the allegation. NA-A verified she was working the afternoon shift on 11/27/21. NA-A stated R1 was yelling and she did not know what she wanted. NA-A stated when R1 yelled out, staff would try to figure out what R1 needed and console R1. NA-A stated she did not witness anyone else make inappropriate comments. On 12/1/21, at 3:14 p.m. during an interview with the DON, the DON stated she believed the allegation to be true. The DON stated she was not sure if NA-A was talking to R1 in a joking manner or if she snapped. The facility's Vulnerable Adult policy dated 7/20/21, directed the purpose of the policy was for the resident to be free from verbal or mental abuse. The policy further directed the facility prohibits abuse and mistreatment of the residents by anyone including staff. The policy described verbal abuse as any use of oral, written or gestured language that willfully included disparaging and derogatory terms to residents within their hearing distance regardless of age, ability to comprehend or disability. Examples of verbal abuse included saying things to frighten a resident.	F 600		
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		1/6/22

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 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE	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 609	Continued From page 4 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 ensure allegations of abuse were reported to the State Agency (SA) immediately (within two hours), for 1 of 3 residents (R1) reviewed for abuse. Findings Include: On 11/29/21, at 1:52 p.m. a Facility Reported Incident (FRI) submitted to the SA allegations of emotional or mental abuse towards R1 which occurred on 11/27/21, at 5:00 p.m. (nearly 45 hours earlier). The description included the incident was reported to the administrator and the	F 609	F609 It is policy of Cassia (Moose Lake Village b.d.a. Augustana Mercy Health Care Center) to comply with F609 To assure continued compliance, the following plan has been put into place; Regarding cited residents: The facility failed to ensure allegations of abuse were reported to the State Agency (SA) immediately (within two hours), for 1 of 3 residents (R1) reviewed for abuse. Action taken to identify other potential residents having similar occurrences: Audit completed of all reportable	

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 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE	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 609	Continued From page 5 director of nursing (DON) on 11/29/21, by nursing assistant (NA)-B. NA-B reported NA-A had made statements of, "Stop yelling, I'm going to shut your door if you don't shut up" to R1. NA-B reported NA-A was also mocking R1's statements of, "Help me." Action taken to protect the resident included NA-A was suspended pending the internal investigation. R1's Face Sheet printed 12/1/21, indicated R1's diagnoses included left femur fracture, finger fracture, unsteadiness, dementia with behavioral disturbances, cognitive impairment and urinary tract infection (UTI). R1's admission Minimum Data Set (MDS) dated 10/24/21, indicated R1 had mildly impaired cognition and had verbal behaviors directed at others. The MDS further indicated R1 required assistance of staff with all activities of daily living (ADLs) except for eating. R1's care plan dated 10/22/21, indicated R1 had a history of expressing self with yelling out for help, frequently requesting assistance, changing her request to the opposite of the previous request and using profanity to insult staff when she was frustrated. R1's hearing was adequate. On 12/1/21, at 2:04 p.m. NA-B was interviewed and stated she worked with NA-A on Saturday, 11/27/21, on the afternoon shift. NA-B stated this was the first time she had worked with NA-A as her partner. NA-B stated she observed NA-A say to R1, "Shut up or I'm going to shut her door." NA-B stated NA-A yelled this from R1's doorway. NA-B stated NA-A was also mocking R1 saying, "Help, Help, shut up [R1]." NA-B stated she did not see R1's response, but R1 would get quiet,	F 609	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 records filed for alleged reports of abuse conducted on 12/15/2021. Measures put into place to ensure deficient practice does not recur: Staff for the facility including all departments (whole-house) were re-educated via verbal read and sign documentation on resident rights including, but not limited to Vulnerable Adult reporting and allegations of reported abuse starting on 12/1/2021 and 12/6/2021; will be completed by 1/6/2021. Further, staff will be re-educated via mandatory in-person meeting on what qualifies as abuse and the importance of reporting suspected or alleged reports of abuse in an appropriate timeframe by 1/6/2022. Effective implementation of actions will be monitored by: The facility leadership, or designee(s) will audit through [(three) staff and (six) resident] interviews randomly, monthly for the next 90 days to ensure verbal and other abuse does not occur. 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	

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 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE	**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 609	Continued From page 6 and then return to yelling. NA-B stated NA-A said these statements at least three times during a short period of time after dinner. NA-B stated R1 yelled out help quite consistently, even when they were helping her. Hearing NA-A's statements to R1 bothered NA-B, but NA-B did not do anything and knew it was wrong. NA-B stated she did not report the incident until Monday 11/29/21, as she felt there was tension between the other staff. NA-B further stated TMA-A and LPN-A were also present when NA-A was mocking R1 and telling R1 to shut up. NA-B waited and reported the incident because she was afraid of retaliation. On 12/1/21, at 3:14 p.m. during an interview with the DON, the DON stated she believed the allegation to be true. The DON stated she was not sure if NA-A was talking to R1 in a joking manner or if she snapped. The DON stated she would expect all staff to report allegations of abuse immediately to her or to the immediate supervisor. The facility's Vulnerable Adult policy dated 7/20/21, directed each employee was responsible to report without the fear of reprisal immediately any knowledge of suspected or alleged abuse immediately to the designated staff such as the DON, social services or nursing supervisor.	F 609	will be: The Director of Nursing or designee is responsible for maintain compliance. Completion date for certification purposes only is: January 6, 2022.	

Electronically delivered
December 8, 2021

Administrator
Moose Lake Village
710 South Kenwood Avenue
Moose Lake, MN 55767

Re: State Nursing Home Licensing Orders
Event ID: K35Y11

Dear Administrator:

The above facility was surveyed on December 1, 2021 through December 1, 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, Rapid Response
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
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 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE	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) COMPLETE DATE
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 12/1/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure. The following complaint was found to be	2 000		

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 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE	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) COMPLETE DATE
2 000	Continued From page 1 SUBSTANTIATED: H5491058C (MN78985), with a licensing order issued at 626.557 Subd. 3. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	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	21980		1/6/22

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 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE	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) COMPLETE DATE
21980	Continued From page 2 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 (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 to the State Agency (SA) immediately (within two hours), for 1 of 3 residents (R1) reviewed for abuse. Findings Include: On 11/29/21, at 1:52 p.m. a Facility Reported Incident (FRI) submitted to the SA allegations of emotional or mental abuse towards R1 which occurred on 11/27/21, at 5:00 p.m. (nearly 45 hours earlier). The description included the	21980	It is policy of Cassia (Moose Lake Village b.d.a. Augustana Mercy Health Care Center) to comply with F609 To assure continued compliance, the following plan has been put into place; Regarding cited residents: The facility failed to ensure allegations of abuse were reported to the State Agency (SA) immediately (within two hours), for 1 of 3 residents (R1) reviewed for abuse. Action taken to identify other potential residents having similar occurrences: Audit completed of all reportable	

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 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE	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) COMPLETE DATE
21980	Continued From page 3 incident was reported to the administrator and the director of nursing (DON) on 11/29/21, by nursing assistant (NA)-B. NA-B reported NA-A had made statements of, "Stop yelling, I'm going to shut your door if you don't shut up" to R1. NA-B reported NA-A was also mocking R1's statements of, "Help me." Action taken to protect the resident included NA-A was suspended pending the internal investigation. R1's Face Sheet printed 12/1/21, indicated R1's diagnoses included left femur fracture, finger fracture, unsteadiness, dementia with behavioral disturbances, cognitive impairment and urinary tract infection (UTI). R1's admission Minimum Data Set (MDS) dated 10/24/21, indicated R1 had mildly impaired cognition and had verbal behaviors directed at others. The MDS further indicated R1 required assistance of staff with all activities of daily living (ADLs) except for eating. R1's care plan dated 10/22/21, indicated R1 had a history of expressing self with yelling out for help, frequently requesting assistance, changing her request to the opposite of the previous request and using profanity to insult staff when she was frustrated. R1's hearing was adequate. On 12/1/21, at 2:04 p.m. NA-B was interviewed and stated she worked with NA-A on Saturday, 11/27/21, on the afternoon shift. NA-B stated this was the first time she had worked with NA-A as her partner. NA-B stated she observed NA-A say to R1, "Shut up or I'm going to shut her door." NA-B stated NA-A yelled this from R1's doorway. NA-B stated NA-A was also mocking R1 saying, "Help, Help, shut up [R1]." NA-B stated she did not see R1's response, but R1 would get quiet,	21980	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 records filed for alleged reports of abuse conducted on 12/15/2021. Measures put into place to ensure deficient practice does not recur: Staff for the facility including all departments (whole-house) were re-educated via verbal read and sign documentation on resident rights including, but not limited to Vulnerable Adult reporting and allegations of reported abuse starting on 12/1/2021 and 12/6/2021; will be completed by 1/6/2021. Further, staff will be re-educated via mandatory in-person meeting on what qualifies as abuse and the importance of reporting suspected or alleged reports of abuse in an appropriate timeframe by 1/6/2022. Effective implementation of actions will be monitored by: The facility leadership, or designee(s) will audit through [(three) staff and (six) resident] interviews randomly, monthly for the next 90 days to ensure verbal and other abuse does not occur. 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:	

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 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE	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) COMPLETE DATE
21980	Continued From page 4 and then return to yelling. NA-B stated NA-A said these statements at least three times during a short period of time after dinner. NA-B stated R1 yelled out help quite consistently, even when they were helping her. Hearing NA-A's statements to R1 bothered NA-B, but NA-B did not do anything and knew it was wrong. NA-B stated she did not report the incident until Monday 11/29/21, as she felt there was tension between the other staff. NA-B further stated TMA-A and LPN-A were also present when NA-A was mocking R1 and telling R1 to shut up. NA-B waited and reported the incident because she was afraid of retaliation. On 12/1/21, at 3:14 p.m. during an interview with the DON, the DON stated she believed the allegation to be true. The DON stated she was not sure if NA-A was talking to R1 in a joking manner or if she snapped. The DON stated she would expect all staff to report allegations of abuse immediately to her or to the immediate supervisor. The facility's Vulnerable Adult policy dated 7/20/21, directed each employee was responsible to report without the fear of reprisal immediately any knowledge of suspected or alleged abuse immediately to the designated staff such as the DON, social services or nursing supervisor. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility should re-educate staff identified in the citation to policies and procedures, and audit all complaints of alleged abuse or neglect for a set determined time. The results of those audits should be taken to the Quality Assurance Performance	21980	The Director of Nursing or designee is responsible for maintain compliance. Completion date for certification purposes only is: January 6, 2022.	

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 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE	**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) COMPLETE DATE
21980	Continued From page 5 Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		