

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 Therefore, the NATCEP prohibition is rescinded.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



Protecting, Maintaining and Improving the Health of All Minnesotans

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.

Moose Lake Village December 8, 2021 Page 2

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

Moose Lake Village December 8, 2021 Page 3

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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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.

Moose Lake Village December 8, 2021 Page 4 Feel free to contact me if you have questions.

Sincerely,

S 6

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			ORM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	•	OMB	3 NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X3	3) DATE SURVEY COMPLETED
		245491	B. WING _		C 12/01/2021
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	
MOOSE	LAKE VILLAGE			710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 000	INITIAL COMMENT	ſS	F 00	0	
	completed at your f investigation. Your	dard abbreviated survey was acility to conduct a complaint facility was found to be not in CFR Part 483, Requirements Facilities.			
		laint was found to be H5491058C (MN78985), with t F600 and F609.			
F 600 SS=D	signature is not req page of the CMS-2 correction is require acknowledge receip Free from Abuse ar	ot of the electronic documents. Ind Neglect	F 60	0	1/6/22
	Exploitation The resident has th neglect, misapprop and exploitation as includes but is not I corporal punishmer	rom Abuse, Neglect, and e right to be free from abuse, riation of resident property, defined in this subpart. This imited to freedom from nt, involuntary seclusion and mical restraint not required to medical symptoms.			
	§483.12(a) The fac	ility must-			
	physical abuse, cor involuntary seclusic This REQUIREMEN by: Based on interview	use verbal, mental, sexual, or poral punishment, or on; NT is not met as evidenced v, and document review, the e residents were free from		F600 This Plan of Correction constitutes my	Y
	-				
LABORATORY	Y DIRECTOR'S OR PROVIE	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE 12/17/2021

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.

PRINTED: 12/23/2021

		AND HUMAN SERVICES		(APPROVE 0938-039
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245491	B. WING			C 01/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/	
MOOSE	LAKE VILLAGE			710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 600	Continued From pa	ige 1	F 6	00		
	verbal abuse for 1 of 3 residents (R1) reviewed for verbal abuse.			written allegation of compliance for deficiencies cited. However, subn	nission	
	Findings Include:			of this Plan of Correction is not ar admission that a deficiency exists one was cited correctly. The Plan	or that	
	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).			Correction is submitted to meet requirements established by State Federal law. It is policy of Cassia (Moose Lake	e and Village	
	R1's admission Mir	^{,.} nimum Data Set (MDS) dated R1 had mildly impaired		b.d.a. Augustana Mercy Health C Center) to comply with F600 To a continued compliance, the followi has been put into place;	ssure	
	cognition and had volution others. The MDS fu	verbal behaviors directed at urther indicated R1 required		Regarding cited residents: The facility failed to ensure reside free from verbal abuse for 1 of 3		
	(ADLs) except for e	-		(R1) reviewed for verbal abuse. Action taken to identify other pote	ntial	
	a history of express	ed 10/22/21, indicated R1 had sing self with yelling out for juesting assistance, changing		residents having similar occurren All interview-able potentially affec residents' interviews were conduc	ted	
	request and using	opposite of the previous profanity to insult staff when R1's hearing was adequate.		ensure that no further reports of a verbal abuse were noted. No furth reports of verbal abuse were four	ner	
	A Facility Reported	Incident (FRI) submitted to SA) on 11/29/21, at 1:52 p.m.		facility resident interviews. Measures put into place to ensure deficient practice does not recur:	Ũ	
	identified allegation abuse towards R1	s of emotional or mental which occurred on 11/27/21, at		Staff for the facility including all departments (whole-house) were		
	was reported to the of nursing (DON) o	ription included the incident administrator and the director n 11/29/21, by nursing		re-educated via verbal read and s documentation on resident rights including, but not limited to Vulne	able	
	statements of, "Sto	IA-B reported NA-A had made p yelling, I'm going to shut n't shut up" to R1. NA-B		Adult reporting and allegations of abuse starting on 12/1/2021 and 12/6/2021; will be completed by 1		
	reported NA-A was of, "Help me." Actic	also mocking R1's statements on taken to protect the resident suspended pending the		Further, staff will be re-educated mandatory in-person meeting on qualifies as abuse and the import reporting suspected or alleged re	via what ance of	

Facility ID: 00049

If continuation sheet Page 2 of 7

		AND HUMAN SERVICES				FORM	12/23/2021 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		245491	B. WING _				C 01/2021
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
MOOSE	LAKE VILLAGE				0 SOUTH KENWOOD AVENUE OOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	On 12/1/21, at 12:4 (FM)-A was intervie was notified of the a stated R1 had beer to admission, her c but could be louder FM-A stated he did yelled out as R1 ha probably would hav shut up, and stated FM-A stated R1 had weren't gone. On 12/1/21, at 2:04 and stated she wor 11/27/21, on the aft was the first time sl her partner. NA-B st to R1, "Shut up or I NA-B stated NA-A y NA-B stated NA-A y Help, Help, shut up not see R1's respon and then return to y these statements a short period of time yelled out help quite were helping her. H R1 bothered NA-B, and knew it was wr report the incident of felt there was tension NA-B further stated present when NA-A R1 to shut up. NA-E incident because sl	ge 2 2 p.m. R1's family member wed. FM-A stated he was alleged verbal abuse. FM-A n calling out for help since prior alls for help were not that loud, now now due to a recent UTI. not know if R1 intentionally d dementia. FM-A stated R1 e heard NA-A telling her to R1 would have been upset. d dementia, but her senses p.m. NA-B was interviewed ked with NA-A on Saturday, ernoon shift. NA-B stated this he had worked with NA-A as stated she observed NA-A say 'm going to shut her door." yelled this from R1's doorway. was also mocking R1 saying, o [R1]." NA-B stated she did hse, but R1 would get quiet, velling. NA-B stated NA-A said t least three times during a e after dinner. NA-B stated R1 e consistently, even when they learing NA-A's statements to but NA-B did not do anything ong. NA-B stated she did not until Monday 11/29/21, as she on between the other staff. TMA-A and LPN-A were also a was mocking R1 and telling B waited and reported the ne was afraid of retaliation. p.m. NA-A was interviewed.	F 60	00	abuse in an appropriate timeframe 1/6/2022. Effective implementation of actions monitored by: The facility leadership, or designeer audit through [(three) staff and (six) resident] interviews randomly, moni- the next 90 days to ensure verbal a other abuse does not occur. Result these audits will be reviewed by the QAPI committee and they will make decision if further monitoring/audits recommended. Those responsible to maintain com- will be: The Director of Nursing or designeer responsible for maintain compliance Completion date for certification pu- only is: January 6, 2022.	will be (s) will (s) will thly for and s of e facility e the are opliance e is e.	

If continuation sheet Page 3 of 7

		AND HUMAN SERVICES				FORM	12/23/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245491	B. WING				C 01/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOOSE	LAKE VILLAGE				10 SOUTH KENWOOD AVENUE IOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	door, and denied m did not know who w NA-A verified she w on 11/27/21. NA-A s did not know what s R1 yelled out, staff needed and console witness anyone else comments. On 12/1/21, at 3:14 the DON, the DON allegation to be true not sure if NA-A wa manner or if she sn The facility's Vulner 7/20/21, directed th for the resident to b abuse. The policy fip prohibits abuse and by anyone including verbal abuse as any gestured language disparaging and de within their hearing ability to compreher	R1 to shut up or I'll shut the locking R1. NA-A stated she yould report the allegation. vas working the afternoon shift stated R1 was yelling and she she wanted. NA-A stated when would try to figure out what R1 e R1. NA-A stated she did not e make inappropriate e. p.m. during an interview with stated she believed the e. The DON stated she was is talking to R1 in a joking	Fe	500			
F 609 SS=D	Reporting of Allege		FØ	609			1/6/22
		onse to allegations of abuse, n, or mistreatment, the facility					
	§483.12(c)(1) Ensu	re that all alleged violations					

Facility ID: 00049

If continuation sheet Page 4 of 7

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FI		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				O	MB NO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONS	STRUCTION	-	COM	E SURVEY PLETED
		245491	B. WING _			_		C 01/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STA	TE, ZIP CODE		
MOOSE	LAKE VILLAGE				JTH KENWOOD AV			
moool				MOOSE	E LAKE, MN 5576	67		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTIVI ROSS-REFERENCED		BE	(X5) COMPLETION DATE
F 609	mistreatment, inclus source and misapp are reported immed hours after the alleg that cause the alleg serious bodily injury the events that caus abuse and do not re- the administrator of officials (including ta adult protective ser- for jurisdiction in lor accordance with Sta procedures. §483.12(c)(4) Repo- investigations to the designated represe accordance with Sta Survey Agency, with incident, and if the a appropriate correction This REQUIREMEN by: Based on interview facility failed to ensi- reported to the Stat (within two hours), for reviewed for abuse Findings Include: On 11/29/21, at 1:50 Incident (FRI) subm- emotional or menta occurred on 11/27/2 hours earlier). The	glect, exploitation or ding injuries of unknown ropriation of resident property, diately, but not later than 2 gation is made, if the events jation involve abuse or result in γ , or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to the facility and to other o the State Survey Agency and vices where state law provides ng-term care facilities) in ate law through established of the results of all e administrator or his or her intative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified ive action must be taken. NT is not met as evidenced γ and document review, the ure allegations of abuse were the Agency (SA) immediately for 1 of 3 residents (R1)	F 60	F60 It is b.d.a Cent cont has Rega The abus (SA) of 3 Actio resio		(Moose Lake V ercy Health Car ith F609 To ass ce, the following ace; dents: ensure allegation to the State A ithin two hours eviewed for ab tify other poten illar occurrence	re sure g plan ons of gency), for 1 use. tial	
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: K35Y11		Facility ID: 0	00049	If continu	ation she	et Page 5 of 7

PRINTED: 12/23/2021

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/23/2021 APPROVED 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245491	B. WING				C 01/2021
NAME OF PR	OVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
					10 SOUTH KENWOOD AVENUE		
MOOSE LA	AKE VILLAGE				100SE LAKE, MN 55767		
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r a s y r c iii iii F c f f c f f c c f f c c a () F a i f r c c a () F a f r c c a s y r c c f c f c f c f c f f c f f f f f f	assistant (NA)-B. N statements of, "Stop our door if you dor eported NA-A was of, "Help me." Actio ncluded NA-A was internal investigatio R1's Face Sheet pre- diagnoses included racture, unsteadined isturbances, cogni ract infection (UTI) R1's admission Min 10/24/21, indicated cognition and had v others. The MDS fund assistance of staff v ADLs) except for e R1's care plan date a history of express help, frequently requer request to the o equest and using p she was frustrated. Dn 12/1/21, at 2:04 and stated she worl 1/27/21, on the aft vas the first time sh her partner. NA-B s o R1, "Shut up or I" VA-B stated NA-A v Help, Help, shut up	DON) on 11/29/21, by nursing A-B reported NA-A had made p yelling, I'm going to shut of shut up" to R1. NA-B also mocking R1's statements in taken to protect the resident suspended pending the n. inted 12/1/21, indicated R1's left femur fracture, finger ess, dementia with behavioral tive impairment and urinary imum Data Set (MDS) dated R1 had mildly impaired rerbal behaviors directed at inther indicated R1 required with all activities of daily living	F	609	events/incidents in the past 90 days conducted to ensure that they were reported in the required timeframe. additional concerns found during au records filed for alleged reports of a 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 sig documentation on resident rights including, but not limited to Vulneral Adult reporting and allegations of re abuse starting on 12/1/2021 and 12/6/2021; will be completed by 1/6 Further, staff will be re-educated via mandatory in-person meeting on wi qualifies as abuse and the importar reporting suspected or alleged repo- abuse in an appropriate timeframe 1/6/2022. Effective implementation of actions monitored by: The facility leadership, or designeet audit through [(three) staff and (six) resident] interviews randomly, mon- the next 90 days to ensure verbal a other abuse does not occur. The Di of Nursing, or designee will audit all reportable events/incidents for the r days to ensure that all reports are fi with the appropriate parties within the required timeframe. Results of thes audits will be reviewed by the facility committee and they will make the d if further monitoring/audits are recommended. Those responsible to maintain com	No udit of abuse in ble ported /2021. a hat hce of orts of by will be (s) will thly for nd irector l he se y QAPI ecision	

Facility ID: 00049

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &					FORM	12/23/2021 APPROVED 0938-0391
	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
	245491	B. WING _				C 01/2021
NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MOOSE LAKE VILLAGE				0 SOUTH KENWOOD AVENUE OOSE LAKE, MN 55767		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
these statements at le short period of time af yelled out help quite co were helping her. Hea R1 bothered NA-B, bu and knew it was wrong report the incident unti- felt there was tension NA-B further stated TM present when NA-A wa R1 to shut up. NA-B w incident because she On 12/1/21, at 3:14 p.1 the DON, the DON sta allegation to be true. T not sure if NA-A was ta manner or if she snap would expect all staff t abuse immediately to supervisor. The facility's Vulnerab 7/20/21, directed each to report without the fe any knowledge of susp	ing. NA-B stated NA-A said east three times during a fter dinner. NA-B stated R1 consistently, even when they aring NA-A's statements to ut NA-B did not do anything g. NA-B stated she did not til Monday 11/29/21, as she between the other staff. MA-A and LPN-A were also ras mocking R1 and telling vaited and reported the was afraid of retaliation. m. during an interview with ated she believed the The DON stated she was talking to R1 in a joking oped. The DON stated she to report allegations of her or to the immediate ble Adult policy dated n employee was responsible ear of reprisal immediately spected or alleged abuse signated staff such as the	F 60	09	will be: The Director of Nursing or designed responsible for maintain complianc Completion date for certification pu only is: January 6, 2022.	e.	

Facility ID: 00049

If continuation sheet Page 7 of 7



Protecting, Maintaining and Improving the Health of All Minnesotans

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 <u>only a suggestion</u> 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 <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>. 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.

Moose Lake Village December 8, 2021 Page 2

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			
		00049	B. WING	S, CITY, STATE, ZIP CODE SNWOOD AVENUE MN 55767 ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MOOSE	LAKE VILLAGE		H KENWOO AKE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	COMPLETE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defice herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	your facility by surv Department of Hea	rS: blaint survey was conducted at eyors from the Minnesota lth (MDH). Your facility was ance with the MN State				
		laint was found to be				
	epartment of Health Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SUR COMPLETE		
			A. DOILDING.			С	
		00049	B. WING			01/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
MOOSE	LAKE VILLAGE		TH KENWOOD				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
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2 000	Continued From pa	ige 1	2 000				
		H5491058C (MN78985), with sued at 626.557 Subd. 3.					
	documenting the Si Orders using Feder The facility is enroll signature is not req page of state form. is required, it is req	partment of Health is tate Licensing Correction ral software. ed in ePOC and therefore a uired at the bottom of the first Although no plan of correctior uired that the facility of of the electronic documents	1				
21980	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 3 Reporting - Inerable Adults	21980			1/6/22	
	reporter who has revulnerable adult is lor who has knowled has sustained a phyreasonably explained information to the condividual is a vulner the individual is adur reporter is not required.	of report. (a) A mandated eason to believe that a being or has been maltreated, dge that a vulnerable adult ysical injury which is not ed shall immediately report the common entry point. If an erable adult solely because mitted to a facility, a mandated ired to report suspected e individual that occurred prior as:					
	another facility and believe the vulneral previous facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not provisions of this s as described above	as admitted to the facility from the reporter has reason to ble adult was maltreated in the mows or has reason to believe a vulnerable adult as defined by subdivision 21, clause (4). required to report under the ection may voluntarily report by s section requires a report of	•				

Minnesc	ta Department of He	alth			FORM AP	PROVED
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	E CONSTRUCTION	(X3) DATE SU COMPLE	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING	:		IED
		00049	B. WING		C 12/01 /2	2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
MOOSE	LAKE VILLAGE	710 SOU	TH KENWOO	DD AVENUE		
WOUSE		MOOSEI	AKE, MN 5	5767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
21980	Continued From pa	ige 2	21980			
	knows or has reaso been made to the o (d) Nothing in thi reporter from also r agency. (e) A mandated r reason to believe th 626.5572, subdivisi (5), occurred must subdivision. If the r time believes that a agency will determin the reported error w the criteria under se 17, paragraph (c), o facility may provide directly to the lead a how the event mee 626.5572, subdivisi (5). The lead ager	d maltreatment, if the reporter on to know that a report has common entry point. Is section shall preclude a reporting to a law enforcement reporter who knows or has hat an error under section ion 17, paragraph (c), clause make a report under this reporter or a facility, at any an investigation by a lead ne or should determine that vas not neglect according to ection 626.5572, subdivision clause (5), the reporter or e to the common entry point or agency information explaining ts the criteria under section ion 17, paragraph (c), clause making an initial disposition of bdivision 9c.				
	by: Based on interview facility failed to ens reported to the Stat (within two hours), reviewed for abuse Findings Include: On 11/29/21, at 1:5 Incident (FRI) subn emotional or menta occurred on 11/27/2	ent is not met as evidenced and document review, the ure allegations of abuse were the Agency (SA) immediately for 1 of 3 residents (R1) 2 p.m. a Facility Reported hitted to the SA allegations of al abuse towards R1 which 21, at 5:00 p.m. (nearly 45 description included the		It is policy of Cassia (Moose Lake V b.d.a. Augustana Mercy Health Car Center) to comply with F609 To ass continued compliance, the following has been put into place; Regarding cited residents: The facility failed to ensure allegation abuse were reported to the State A (SA) immediately (within two hours) of 3 residents (R1) reviewed for about Action taken to identify other potent residents having similar occurrence Audit completed of all reportable	re sure g plan ons of gency), for 1 use. tial	

Minnesota Department of Health STATE FORM

6899

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000049		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 12/01/2021	
					12/0	1/2021
NAME OF	PROVIDER OR SUPPLIER					
MOOSE	LAKE VILLAGE		AKE, MN 5	DD AVENUE 5767		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)		COMPLET DATE
21980	Continued From pa	ge 3	21980			
	director of nursing (assistant (NA)-B. N statements of, "Stop your door if you dor reported NA-A was of, "Help me." Actio included NA-A was internal investigatio R1's Face Sheet pr diagnoses included fracture, unsteadined disturbances, cogni tract infection (UTI) R1's admission Min 10/24/21, indicated cognition and had v others. The MDS fu assistance of staff v (ADLs) except for e	inted 12/1/21, indicated R1's left femur fracture, finger ess, dementia with behavioral tive impairment and urinary imum Data Set (MDS) dated R1 had mildly impaired rerbal behaviors directed at orther indicated R1 required with all activities of daily living		events/incidents in the past 90 day conducted to ensure that they wer reported in the required timeframe additional concerns found during a records filed for alleged reports of 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 si documentation on resident rights including, but not limited to Vulner Adult reporting and allegations of abuse starting on 12/1/2021 and 12/6/2021; will be completed by 1/ Further, staff will be re-educated v mandatory in-person meeting on v qualifies as abuse and the importa reporting suspected or alleged rep abuse in an appropriate timeframe 1/6/2022. Effective implementation of action monitored by: The facility leadership, or designed	e audit of abuse ign able reported /6/2021. <i>r</i> ia what ance of ports of e by s will be	
	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.			audit through [(three) staff and (six resident] interviews randomly, more the next 90 days to ensure verbal other abuse does not occur. The I of Nursing, or designee will audit a	nthly for and Director	
	and stated she worl 11/27/21, on the aft was the first time sh her partner. NA-B s to R1, "Shut up or I" NA-B stated NA-A y	p.m. NA-B was interviewed ked with NA-A on Saturday, ernoon shift. NA-B stated this he had worked with NA-A as tated she observed NA-A say 'm going to shut her door." velled this from R1's doorway. was also mocking R1 saying,		reportable events/incidents for the days to ensure that all reports are with the appropriate parties within required timeframe. Results of the audits will be reviewed by the facil committee and they will make the if further monitoring/audits are recommended.	e next 90 filed the ese ity QAPI	
	"Help, Help, shut up	o [R1]." NA-B stated she did nse, but R1 would get quiet,		Those responsible to maintain cor will be:	mpliance	

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	0	
		00049	D. WING		12/0	1/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MOOSE	LAKE VILLAGE		TH KENWOO AKE, MN 5			
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLET DATE
21980	Continued From pa	ge 4	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 Director of Nursing or designee is responsible for maintain compliance. Completion date for certification purposes only is: January 6, 2022.		
to report without the fea any knowledge of susp immediately to the desi DON, social services of SUGGESTED METHO administrator or design policies or procedures to of all allegations of abu- appropriate timeframes should re-educate staff policies and procedures of alleged abuse or neg		able Adult policy dated ach employee was responsible e fear of reprisal immediately uspected or alleged abuse designated staff such as the es or nursing supervisor. THOD OF CORRECTION: The signee could develop/revise res to ensure timely reporting abuse or neglect are within mes for reporting. The facility staff identified in the citation to ures, and audit all complaints neglect for a set determined those audits should be taken				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA UND PLAN OF CORPECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00049	B. WING			C 01/2021
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IOOSE	LAKE VILLAGE		TH KENWOOD LAKE, MN 557			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC REGULATORY OR L	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	VE ACTION SHOULD BE COMPLETE ED TO THE APPROPRIATE DATE	
21980	Continued From page 5		21980			
	Improvement (QAPI) committee to determine the need for further monitoring or compliance.					
	TIME PERIOD FOR CORRECTION: 21 DAYS					