

Electronically delivered August 31, 2021

Administrator
First Care Living Center
900 Hilligoss Boulevard Southeast
Fosston, MN 56542

RE: CCN: 245512

Cycle Start Date: July 15, 2021

Dear Administrator:

On August 3, 2021, we notified you a remedy was imposed. On August 19, 2021 the Minnesota Department of Health 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 August 15, 2021.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective August 18, 2021 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of August 3, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 15, 2021. 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 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

August 31, 2021

Administrator
First Care Living Center
900 Hilligoss Boulevard Southeast
Fosston, MN 56542

Re: Reinspection Results

Event ID: DJIC12

Dear Administrator:

On August 19, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 19, 2021. At this time these correction orders were found corrected.

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

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Electronically Submitted August 3, 2021

Administrator
First Care Living Center
900 Hilligoss Boulevard Southeast
Fosston, MN 56542

RE: CCN: 245512

Cycle Start Date: July 15, 2021

Dear Administrator:

On July 15, 2021, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On August 15, 2021, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. However, continued non-compliance remains at the lower scope and severity of F.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 18, 2021.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 18, 2021, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 18, 2021, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 15, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, First Care Living Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 15, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Jen Bahr, RN, Unit Supervisor Bemidji District Office Licensing and Certification Program Health Regulation Division

> Minnesota Department of Health 705 5th Street NW, Suite A Bemidji, MN 56601-2933 Email: Jennifer.bahr@state.mn.us

Office: (218) 308-2104 Mobile: (218) 368-3683

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 their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 15, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40,

et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132

> Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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

PRINTED: 08/18/2021 FORM APPROVED OMB NO. 0938-0391

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	abbreviated and ex at your facility. Your compliance with the Subpart B, Require Facilities. The following comp SUBSTANTIATED: H5512038C (MN74 F600. As part of the invest were cited at F607, The following comp UNSUBSTANTIATE. The survey resulted and Immediate Jed resident safety at Fwhen it was reported and NA-B used prothis was not reported were not provided if further abuse. On 3 that NA-A and NA-I swearing, making in "rough" with R2 and allegation was not reported NA-A told all	stigation related deficiencies at 1648, with a deficiency cited at 1648, F609, F610. Idiant was found to be ED: H5512039C (MN74696) Id in substandard quality of care opardy (IJ) situations to 1600. he IJ began on 3/7/21, and nursing assistant (NA)-A offanity and called R3 names, and to the SA and the residents mmediate protection from 16/8/21, it was reported by staff B were in R2 and R4's room nappropriate jokes and being and R4 in the room; this reported and the residents mmediate protection from 16/5/21, a staff member R2 to shut the F*** up, this reported and the residents					
	further abuse. Alon	mmediate protection from g with another grievance on ident had concerns about how					
LABORATOR)	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE		TITLE		(X6) DATE

Electronically Signed 08/11/2021

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	he was treated by Members reported comments to and a allegation was not residents were not further abuse. The nursing (DON) were 7/12/21, at 4:45 p.m. 7/15/21, at 10:55 at evidence they had a the facility's plan of as your allegation of Departments accept enrolled in ePOC, year the bottom of the form. Your electron be used as verificated Upon receipt of an onsite revisit of your validate that substate regulations has been free from Abuse at CFR(s): 483.12(a)(§483.12 Freedom for Exploitation The resident has the neglect, misappropiand exploitation as includes but is not leading to the corporal punishment any physical or chees.	NA-A. On 6/18/21, staff NA-A made inappropriate bout R1 during cares, this reported timely and again the provided protection from administrator and director of e informed of the IJ on n. The IJ was removed on m. when the facility provided removed the immediacy. If correction (POC) will serve of compliance upon the otance. Because you are your signature is not required e first page of the CMS-2567 ic submission of the POC will tion of compliance. acceptable electronic POC, an or facility may be conducted to ential compliance with the en attained. Ind Neglect 1) rom Abuse, Neglect, and the right to be free from abuse, riation of resident property, defined in this subpart. This imited to freedom from int, involuntary seclusion and mical restraint not required to medical symptoms.	F 00			8/15/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		СОМІ	E SURVEY PLETED
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	director of nursing on 7/12/21, at 4:45 7/15/21, at 10:55 a remained at the lov	(DON) were informed of the IJ p.m. The IJ was removed on .m. but noncompliance ver scope and severity level of		No other concerns (other than concern regarding R2 and NA identified based on the staff in	A-B) were nterviews.	
	for more than minir immediate jeopard	no actual harm with potential mal harm that was not y.		In order to go beyond intervie any signs of potential physica 7/14/21, a facility RN reviewed documentation of weekly skin	l abuse, on od	
	Findings include: a) First Incident 3/7	<i>"/</i> 21.		assessments of R1, R2, R3, R 3/7/21 through 7/12/21. This r not identify any signs or conce	eview did	
	6/1/21, identified R required supervision living (ADL)'S. R3's identified a diagnostic.	mum Data Set (MDS) dated 3 had intact cognition and in to complete activities of daily care plan dated 4/20/21, sis of dementia, decreased need for assistance from staff		physical abuse. No concerns, other than the oreported and substantiated coregarding R1 and NA-A and proncern reported but unsubstantiating Rs and NA-B, were	oncern ootential cantiated identified.	
	indicated registered complaint from a si mean, using profar form indicated R3 r day shift NA's and	nce Form dated 3/7/21, d nurse (RN)-A received a taff member of staff being nity and calling R3 a name. The reported similar information to remained consistent when A. The grievance further		Care plan for R1, R2, R3, and updated with individualized in to address the risk factors ide individually made these reside vulnerable. This process is s detailed in the systematic characteristic Resident Care Plans Updated	terventions entified that ents ubsequently inge	
	indicated a night sh (LPN) reported the member (FM) calle similar concerns. In indicated she intervation NA-A and NA-B Correlating text me NA-A identified the - A documented into a.m. identified RN-	nift licensed practical nurse complaint and R3's family and and reported R3 had told her mmediate action by nurse viewed R3 and sent messages asking for their input.		NA-A was terminated on 6/25 facility substantiated the alleg occurred on 6/18/21. From 7/ charge nurses conducted car observations/audits of NA-B oworked shifts, with no concern Effective 7/20, the SSD and/odaily random audits of two residentify any new incidents of pabuse or neglect as subseque in the systematic change Dail Staff Care. Any concerns will	ation that 19 to 7/31, e during ns noted. or RNs began sidents, to cotential ently detailed y Audits of	

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F 600	morning about the her room last nigh language and calle know ASAP if som this is unacceptabe the complaint furth message indicated he left the same rethe girls working the Girls working the Another interview RN-A; "I would like been watching my about it." The gries services director (indicated R3 agreen or resolution was not reported to the protect the resider weekend. The incident weekend way and called her a B****. could be considered had reported the immorning. b) Second Incident R4's quarterly MD had severe cognit total assistance from the incident way and called her a B****.	e 2 small thin girls who were in the being mean and using horrible ed her a bitch. Please let me nething happened, obviously let and we need to investigate her. Thanks." A second duter. Thanks." A second duter. Thanks. A second duter. Thanks a second duter a language since I got talked to eat to know who because I have a language since I got talked to eat to know who because I have a language since I got talked to eat to know who because I have a language since I got talked to eat to know who because I have a language since I got talked to eat to know who because I have a language since I got talked to eat the letter was signed by the social SSD)-A and the resolution, however, identified. The allegation was a SA, nor were measures to eat the sidentified and implemented. In 7/12/21, at 12:11 a.m. RN-A and ident was reported to RN-A and evance report. RN-A stated R3 bout the two girls swearing on and said there were only two A and NA-B). RN-A interviewed R3 reported that the NA's had RN-A stated, "I suppose it ed verbal abuse." Further, RN-A incident to the DON that	F6	immediately reported to the or the Director of Nursing we to the Administrator, and remade to the SA as required audits will be conducted thr 12, 2021, at which time the QAPI committee will review any, and determine the need audits and frequency. All staff completed addition vulnerable adults and repor requirements subsequently systematic change Suppler Education on Vulnerable Adspecifically, Administrator and Nursing have completed the training for LTC: Vulnerable 13,2021, completed the contained in the Certificate to the RN staff development NA-B completed this training competency on 7/11/21. The survey tags, regarding reviewed under the Essention of Just Culture on 8/11/21, is intended to provide an objust Culture on 8/11/21, is intended to provide an objust Culture on the Essention of Just Culture on the Ess	who will report ports will be a l. The daily rough August facility so findings, if a d for further all training on ting a detailed in the mental dults. It is and Director of a Educare and Director of a Educare and Director of a Educare and Director of a completion at coordinator. It is process to be process objective guide a suggested a suggested a coutcomes. It is process objective dults are objective guide a suggested a coutcomes. It is process objective dults are objective dults are objective dults. It is process objective dults are objective dults are objective dults. It is process objective dults are objective dults are objective dults are objective dults. It is process objective dults are objective dults are objective dults. It is process objective dults are objective dults are objective dults are objective dults. It is process objective dults are objective dults.	

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		245512	B. WING		07/1	; 5/2021
	PROVIDER OR SUPPLIER ARE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542		-
(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 APPROFILITION DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 600	Continued From parand impaired mobil with ADL's. A Resident Grievar indicated NA-C rephandwritten note the you about the incidence weekend. On Satur NA-B] were in [R4 and helping them get remaking inappropriation rough with both resident and did not signed by SSD-A and agreed with the residents identified. The the SA, nor were more indicated NA-D repand the administration.	ge 5 ity and directed staff to assist ace Form dated 3/8/21, orted to the DON via a e following: "I want to inform ents that happened this day night 3/6, [NA-A and and R3]'s room while I was ady for bed. Both girls were te jokes, swearing and being idents." The form indicated the vith R3 and R3 stated he did R4 did not remember the t comment. The grievance was and the DON and indicated R3 olution, however, no resolution allegation was not reported to easures to protect the or implemented. 5/21. ace Form dated 4/5/21, orted via e-mail to the DON or on 4/5/21, at 11:39 p.m. " I	F 600	Protection/Vulnerable Adult policy procedure to reflect the federal regand protection requirements. The policy includes reporting to the Administrator and State Agency immediately (no later than 2 hours being aware of the allegation of about neglect) for all the allegations of president abuse. The policy further that the facility will ensure the allegation and removed from the pending outcome of the investigation of the investigation. Specific revisions to the policy included in the systemic change Regardless and Staff Education. Specific revisions to the policy includes the alleged perpetrator is staff, asset the alleged perpetrator is notified of investigatory suspension, and remarks from the facility pending outcome investigation.	and porting updated after puse or otential states ged igatory e facility ion. ntly evisions dure ude: abuse nt that sure that sure that of the ove of the	
	the evening but I ju working my schedul 11:30 p.m. and I can between another st NA-D had gone into them with p.m. care night. During the can comments to NA-A remembering all of NA-A told R3 to "sh assisting R4, told h	ding you this e-mail so late in st got home from the facility led shift from 2:00 p.m. until n't sleep with what happened aff and a resident." NA-A and o R3 and R4's room to assist as and get into bed for the ares R3 had made some. NA-D indicated not the details but shortly after ut the F*** up." Then while im in an upset tone that she sidents being mean to her		2) The inclusion of federal regular required time frames for reporting suspected abuse. The policy now immediately or as soon as possible to Administrator & OHFC for serious bodily injury or allegations of abustater than 2 hours of forming the sor being notified of an allegation a within 24 hours of forming the susbeing notified of an allegation if the suspicion or allegation does not in abuse or did not result in serious being injury.	states: e, report us e, no uspicion nd picion or e volve	

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		245512	B. WING			07/) 1 5/2021
NAME OF E	PROVIDER OR SUPPLIER	2-0012			TREET ADDRESS, CITY, STATE, ZIP CODE	077	15/2021
NAIVIE OF F	ROVIDER OR SUPPLIER						
FIRST C	ARE LIVING CENTER			_	00 HILLIGOSS BOULEVARD SOUTHEAST COSSTON, MN 56542		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	when she was only wrote, "I'm bringing as a mandated reproduction of the provided several of the witnessed similar a grievance was sign and indicated R3 at however, no resolution allegation was not remeasures to protect implemented. d) Fourth Incident 4	trying to help them. NA-D this to your attention because orted it's my responsibility to g a vulnerable adult being bal attacks." The e-mail further ther staff members who had ctions by NA-A. The ed by the SSD-B and the DON greed with the resolution, tion was identified. The reported to the SA, nor were at the residents identified or	F	600	3) The inclusion of a process for interviewing other staff or residents may have knowledge of abuse: a. The investigation will include, u Just Culture Principles from Essent Health: i. Review all documents which m include: the medical record, assign care plan, all documentation, and employee personnel record(s). ii. Review of any electronic surveif applicable. iii. Interviews of staff, residents, volunteers, and family members, as appropriate	asing tia ay ments, illance,	
	had moderate cogrextensive assistance R2's care plan date mobility related to with directed staff to assistant transfers. R2's progress note complained of pain could do he began indicated he had not questioned why he "because everyone" A second Resident identified R2 stated verbal comments a interview with R2 stated swore of not but state buttons. Interviews	dated 5/4/21, indicated R2 attive impairment and required be from two staff for ADL's. at 5/13/21, identified impaired weakness and pain and sist with bed mobility and dated 3/7/21, indicated R2 and when asked what staff yelling at staff. Later R2 at slept all night and when did not say anything replied, gets sassy with me if I do." Grievance Form dated 4/5/21, there was inappropriate and behaviors from NA-A. The stated he was not sure if NA-A ated NA-A pushes their with a staff member identified d rude with residents.			The facility has updated its grievand policy and form updated on 7/14/21 include an immediate review for possible abuse or neglect. Residents and/or representatives were educated on report grievances or concerns about resident care, via the weekly facility newsletter on 7/15/21, with staff train on 8/4/21 and 8/5/21. The SSD and will provide ongoing education to residents and/or representatives duscheduled care conferences on the grievance procedure and Resident Rights. This corrective action is subsequently detailed in the system change Revisions to Facility Grieva Policy/Form and Reporting Education. How the facility will identify other rehaving the potential to be affected by same deficient practice.	how to ut / ining d/or RN uring Bill of nic nnce on.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		E SURVEY IPLETED
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		245512	B. WING _			15/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
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FIRST CA	ARE LIVING CENTER	₹		FOSSTON, MN 56542		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)
PRÉFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE ROPRIATE	COMPLETION DATE
F 600	Continued From p	age 7	F 60	00		
		n 7/12/21, at 11:39 a.m. R2				
		hort tempered and had a "bad		R1 was unable to be interviewe		
		NA-A used the F word and said		his passing from end stage pro		
		outh and she was so impatient."		7/16/21. R2 was interviewed or		
		e's got a bad mouth, but I didn't		and relayed concerns with NA-		
	want to make any	trouble.		consistent with staff reports to NA-A during the survey. R3 an		
	c) Fifth Incident 6/	18/21		interviewed on 7/12/21 and did		
	o) i iitii iiiolaciit o/	10/21.		concerns regarding verbal or o		
	R1's significant ch	ange MDS dated 6/16/21,		during the interviews. All other		
		ognitive impairment and		(in addition to R2, R3, and R4)		
		e of two staff for ADL's and		interviewed on 7/12/21 and 7/1		
	was incontinent of	bowel and bladder. R1's care		not raise concerns regarding ve	erbal or	
		identified diagnoses of		other abuse during the interview	vs.	
		red mobility and required staff				
	to assist with all Al	DL's.		On 7/12 and 7/13, all nursing h		
	A Decident Orieva	noo Forms dated 6/40/04		were interviewed and asked to		
		nce Form dated 6/18/21, nd NA-E reported NA-A using		concerns of potential resident a potential concern was identified		
		uage. The form indicated on		R2 and NA-B. This concern was		
		a text message was sent from		immediately reported to the Ad		
		and indicated: "FYI, issues with		and SA on 7/14/21. MDH review		
		night. [LPN-A] has statements		report and closed it on 7/16/21.		
		witnessed her behavior and		concern was not substantiated		
		or to review concerns about		ensure nothing from the initial		
		night." An untitled undated		investigation was missed, from		
		d during the evening of		7/31, charge nurses conducted		
		NA-F were assisting R1 to		observations/audits of NA-B du	•	
		rening. R1 had been incontinent		worked shifts, with no concerns		
		A-A to assist. NA-A entered the the door and stated		No other concerns (other than regarding R2 and NA-B) were i		
		need to help, this F***** stinks		based on the staff interviews.	Jenninea	
		oviding care NA-A stated R1		based on the stall litterviews.		
		the time, " and "why do you		In order to go beyond interview	s to identify	
		**** poop on you, this is		any signs of potential physical a		
		also told R1, "shut the F*** up,		7/14/21, a facility RN reviewed	,	
		* pain." LPN-A moved NA-A to		documentation of weekly skin		
		the building. During a meeting		assessments of R1, R2, R3, R4	l from	
	on 6/19/21, NA-A	denied using foul language and		3/7/21 through 7/12/21. This re	view did	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			A. BOILDII			2
		245512	B. WING_			15/2021
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI		
FIDOT CAR	DE LIVING CENTER			900 HILLIGOSS BOULEVARD SOUTH	EAST	
FIRST CAP	RE LIVING CENTER	L		FOSSTON, MN 56542		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
riss ri	the was burnt out of the port indicated NA During interview or DON stated prior to the pool in the poo	on another wing and stated from the South wing. The A-A was terminated on 6/25/21. 17/12/21, at 11:16 a.m. the othe incident on 6/18/21, there concerns about NA-A. The allegation by another staff R2 and R4 and stated R2 had on it. The DON stated R2 knew and tried to cover for her. Ucated about her swearing and used she would be terminated. The incident is why a grievance report is worried about it." The reported to the SA but knew it that's why a grievance report is stated after the incident and not notified her or the otified the oncoming RN the ner, LPN-A should have and notified the administrator. The started the grievance is because she was notified the in placed under her door and	F 6	not identify any signs or concephysical abuse. No concerns, other than the oreported and substantiated coregarding R1 and NA-A and proncern reported but unsubstate regarding R2 and NA-B, were will be put in systemic changes made, to each the deficient practice will not a systemic changes made, to each the deficient practice will not a systemic changes made, to each the deficient practice will not a systemic changes and counsel review, has implemented following systemic changes are ensure the deficient practice and conservation and interviews or residents, to identify any new potential abuse or neglect. The RN conducts audits by observinterviews when Social Service is absent. Any concerns will be immediated to the Administrator or the Dir Nursing who will report to the Administrator, and reports will the SA as required by law. The audits of staff care will be conthrough August 12, at which the facility SQAPI committee will service is absent.	originally oncern octential antiated identified. place, or insure that recur. tside legal inted the measures to will not recur: ective 7/20, (SSD) idits (by incidents of the DON and vation and the Designee of the Designee of the post of the control of the made to ese daily iducted ime the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
		245512	B. WING			C	
NAME OF 5	200//2550 00 01/251/55	245512	D. WINO		07/	15/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	_		
FIRST C	ARE LIVING CENTER	1		900 HILLIGOSS BOULEVARD SOUTHEAS	Т		
1 11(01 0)	AIRE EIVING GENTER	•		FOSSTON, MN 56542			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRINCE DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 600	her whatever NA-A other two NA's so twas aware of previner behaviors and When interviewed DON stated the incomplete to the SA as it was DON had not though incident but stated, that's why a grieval stated each of the grievances should and said she though filing a grievance. On 7/12/21, at 1:35 DON were interviewed the incidents handle definition of abuse reported and investment in the door." The DON stated statement of the grievances. The bon statement of the grievance of the grievance. The DON stated statement of the grievance of the grievance of the grievance of the grievance. The pon stated statement of the grievance of t	age 9 bout. RN-B stated LPN-A told had said to R1 made the upset they were in tears. RN-B ous concerns with NA-A about not being appropriate. on 7/12/21, at 12:24 p.m. the sident with R3 was not reported handled as a grievance. The ght about it as a reportable "it is abuse, I took it seriously, nce was completed." The DON incidents identified as have been reported to the SA ght they were covering it by 5 p.m. the administrator and wed. The administrator stated ed as grievances fit the and should have been tigated. The administrator was stiffied about the events but k if the resident was safe and nember on another wing or "out aff were not provided any extra bended during any of the the facility had not completed tent cares to ensure safe atted following the last incident that deen suspended the next ther incidents she had spoken The DON stated there was no NA-B used inappropriate of the residents. Further, the	F 6	,	ility solate was survey. able) will ilnerable assure dents and f abuse ons of tment. otection / edure , as part istrator the then t is policy with a erable etive July federal e will approval re o better approval or better ind rement ossible, OHFC for s of orming		
		nd not interviewed other odetermine if ay other		allegation and within 24 hours of the suspicion or being notified of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			A. BOILDI			c
		245512	B. WING		07/	15/2021
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
FIRST C	ARE LIVING CENTER	2		900 HILLIGOSS BOULEVARD SOUTHE	ST	
111131 0	AILL LIVING CLIVILI	`		FOSSTON, MN 56542		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	residents had been NA-A or NA-B. On 7/13/21, at 8:37 an "attitude" since facility. LPN-B state was disrespectful the did a lot of "on the work. LPN-B state DON hoping she was disrespectful to the work. LPN-B stated DON hoping she was disrespectful to the work. LPN-B stated multiple about NA-A. On 7/14/21, at 1:53 incident occurred to the one first aware LPN-A stated did not should have report LPN-A only had consume inappropriate witnessed NA-A us prior to the incident had been directed did not have any continue she had heard ago. On 7/15/21, at 10:3 stated he relied on stay abreast of polinot to get too in desomething happen investigating, report administrator acknowledge.	Ta.m. LPN-B stated NA-A had she started working at the ed NA-A swore all the time and to the residents and said she spot" education but it did not ed she had reported it to the rould do something about it. iple residents had complained as a.m. LPN-A stated when the retween NA-A and R1, she was of the incident and wrote it up. ot get the full story initially but d her what happened. LPN-A know exactly what to do but led it to the DON right away. Incerns about NA-A and NA-B is language. LPN-A had sing inappropriate language to with R1 but did not think it at a specific resident. LPN-A concerns about NA-B as the last did anything was about a year. B4 a.m. the administrator his leader in specific areas to icies and procedures and tried pth with the details. Once ed he was involved in terms of rting and follow up. The owledged he was not dimmediately when incidents.	F 6	allegation if the suspicion or all does not involve abuse or did r serious bodily injury; (ii) a requithat if the alleged perpetrator is assure that any investigation; a requirement that any investigation conducted in response to an in report also requires interviews staff or residents who may have knowledge or abuse. Staff were on this policy on 8/4/21 and 8/5 new policy and procedure is averaged the nurse stations and staff reference. Revisions to Facility Grievance Policy/Form and Reporting Educations to identify the grievance formediately report the grievance SSD/DON/RN/or Administrator applicable person in charge must be grievance form to determing grievance concerns potential and neglect under the Resident Proplan/Vulnerable Adult policy and procedure, effective July 12, 20 suspicions or abuse or neglect immediately notify the Administ Director of Nursing who will not Administrator. Additionally, residents and/or representatives were educated	ot result in rement staff, ator is ension, anding and (iii) a on cident with other end educated /21. The ailable in ounge for cation: ance form and with clear and end to the st review end if this puse or tection do 21, and if will reator or ify the	

CLIVILI	13 I ON MEDICANE	A MEDICAID SERVICES			U	WID NO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		SURVEY PLETED
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		245512	B. WING				15/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				9	00 HILLIGOSS BOULEVARD SOUTHEAST		
FIRST C	ARE LIVING CENTER			F	OSSTON, MN 56542		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	V	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE
F 600	Continued From pa	age 11	F 6	300			
		a Health Fosston Vulnerable	. `	,,,,	resident care, via the weekly facility	,	
		ocedure dated June 2017,			newsletter on 7/15/21, with staff tra		
		Health Fosston should			on 8/4/21 and 8/5/21. The SSD/RN		
		ce an ongoing abuse			provide ongoing education to resid		
		ne plan should contain an			and/or representatives during sche		
		physical plant, environment			care conferences on the grievance		
		identifying factors which may			procedure and Resident Bill of Rigl		
		it abuse and a statement of			Resident Care Plans Updated: On		
		to be taken to minimize the			7/15/21, the Social Services Design	nee	
	risk of abuse. The	policy identified Immediate as:			reviewed and updated, as needed,	all	
	"as soon as possib	le, but no later than 24 hours			resident care plans in relation to		
		knowledge that the incident			vulnerability risk. The SSD will con		
		received." The policy indicated			complete resident risk observations	s to	
		an electronic submission to the			determine level of vulnerability on		
		eted within 24 hours of the			admission and quarterly. As chang		
	incident.				documented, care plans will be upo with the change as well as respecti		
	- Section IV, Protect	ction of Patient During			interventions.		
		ted all patients, residents and					
		cted from harm during the			Supplemental Education on Vulner	able	
		policy lacked a procedure or			Adults: In addition to the existing a		
	steps to be taken to	o protect residents.			training on vulnerable adults, all sta		
	_				actively working, including the DON		
		ing of Incident, Investigation			nursing home staff and staff from o		
	, , ,	nse to the Results Of the			departments (housekeepers, suppl	У	
		ted reports would be made			chain, lab, therapy, maintenance)		
		director of long term care. The			completed the assigned training Ed		
		e a report was made internally,			LTC: Vulnerable Adult and correlati		
		e to conduct the internal			competency evaluation by 8/10/21.		
		nternal team should interview			hires will also receive this supplem		
		e incident, decide if a safety nd gather information related			annual training on a going forward	Dasis.	
		the alleged perpetrator. The			Specifically, Administrator and Dire	ctor of	
		de interviews with other staff or			Nursing completed the Educare tra		
		have knowledge of abuse.			for LTC: Vulnerable Adult on July 1		
	1001donio wilo illay	have knowledge of abase.			successfully completed the compe		
	The IJ was remove	d on 7/15/21, at 10:55 a.m.			test and turned in the Certificate of		
		erified through interview and			completion to the RN staff develop		
		ne facility had updated their			coordinator. NA-B successfully cor		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	(X3) DATE SURVEY COMPLETED	
245512 B. WING	C 07/15/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	07/15/2021	
FIRST CARE LIVING CENTER 900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
F 600 Continued From page 12 policy on reporting and protecting residents with allegations of abuse; completed a thorough investigation to ensure no other residents had abuse concerns, which included resident interviews and skin assessments of those residents that could not be interviewed; and ensured all staff were educated on the new abuse policy and expectations. How the facility will monitor its correct actions to ensure that the deficient practice is being corrected and will nor recur. Report Log: The facility sSSD implemented the Grievance/ Reports I on 8/6/21 to track any reports to the S ensure facility appropriately responds investigates allegations of potential misconduct in accordance with the law and the facility supdated policy on vulnerable adults and the grievance for process. Monthly Audit: Effective 8/1/21, the SS will conduct a monthly audit of all grievance forms and SA investigative to identify compliance to the revised Facility compliance to the revised Facility opporphiance to the revised Facility opporphia	is rn g the will be staff e and tive ot Log SA to s and w form SD e files	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245512	B. WING			l	C 15/2021
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	,
FIRST C	ARE LIVING CENTER				00 HILLIGOSS BOULEVARD SOUTHEAST OSSTON, MN 56542		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	Continued From pa	ge 13 Abuse/Neglect Policies	F 6		Timely Reporting/Vulnerable Adult Education Audit: in addition, the DC designee will conduct random audit employees working on all shifts to timely reporting and understanding Vulnerable Adult policy and procedure audit schedule will be: 3x/week weeks and then weekly x4 weeks. audit will include 5 employees. Reside the reviewed at the monthly QAPI meetings. The QAPI committee will findings and determine if additional auditing or corrective action is required. The date that each deficiency will be corrected. Compliance date will be 8/15/2021.	ts with verify of the ure. a x4 Each ults will review ired.	
	CFR(s): 483.12(b)(§483.12(b) The fac implement written p §483.12(b)(1) Prohineglect, and exploit misappropriation of §483.12(b)(2) Estalto investigate any s §483.12(b)(3) Incluparagraph §483.95. This REQUIREMEN by: Based on interview	allity must develop and policies and procedures that: bit and prevent abuse, ation of residents and resident property, blish policies and procedures uch allegations, and de training as required at and document review, the are their abuse prohibition and			F 607 Facility, with assistance of outside l	egal	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245512	B. WING			C 15/2021
	PROVIDER OR SUPPLIER ARE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF T	ULD BE	(X5) COMPLETION DATE
F 607	Continued From pa	nge 14	F 60	7		
	investigation. This	ed to reporting, protection and had potential to affect all 34 n the nursing home at the time		counsel review, has implemented following systemic changes/ me ensure the deficient practice will be specified to the systems.	asures to I not recur:	
	Findings include:			Revisions Facility S Resident F Vulnerable Adult Policy and Pro and Staff Education: On 7/12/2	cedure	
	Adult Policy and Prindicated Essentia establish and enfor prevention plan. The assessment of the and it's population encourage or permispecific measures risk of abuse. The lass soon as possibly from the time initial occurred has been for long term care as	a Health Fosston Vulnerable ocedure dated June 2017, Health Fosston should ce an ongoing abuse the plan should contain an physical plant, environment adentifying factors which may it abuse and a statement of to be taken to minimize the policy identified Immediate as: le, but no later than 24 hours knowledge that the incident received." The policy indicated an electronic submission to the eted within 24 hours of the		of the IJ removal plan, the Admand DON of the facility replaced current Essentia Health Resider Protection Plan/ Vulnerable Advand procedure dated June 2017 revised Resident Protection/Vul Adult policy and procedure, effect 12, 2021, to better reflect current regulations. The QAPI committ provide a final review and formation of updated policy on 8/12/21. This updated policy and proced includes the following revisions reflect current federal reporting protection requirements: (i) requirements: (i) requirements: (ii) requirements: (iii) requirements: (iii) requirements: (iiii) requirements: (iiiii) requirements: (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	nistrator the then nt It policy f, with a nerable ctive July nt federal ee will approval ure to better and uirement possible,	
	Investigation indicated clients will be proted investigation. The pasteps to be taken to a Section V, Report and Facility Responding to the policy directed once a team will convent investigation. The instaff involved in the	ction of Patient During ted all patients, residents and cted from harm during the colicy lacked a procedure or co protect residents. cing of Incident, Investigation hase to the Results Of the ted reports would be made director of long term care. The e a report was made internally, e to conduct the internal internal team should interview e incident, decide if a safety and gather information related		reporting to the Administrator & serious bodily injury or allegation abuse, no later than 2 hours of the suspicion or being notified of allegation and within 24 hours of the suspicion or being notified of allegation if the suspicion or alled does not involve abuse or did not serious bodily injury; (ii) a requirement that alleged perpetrator is assure that the alleged perpetration notified of the investigator suspicion and remove from the facility per outcome of the investigation; ar requirement that any investigation.	OHFC for ns of forming f an egation of result in ement staff, tor is ension, ading d (iii) a	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245512	B. WING				C 15/2021
NAME OF F	PROVIDER OR SUPPLIER		l T	S	TREET ADDRESS, CITY, STATE, ZIP CODE	011	13/2021
					00 HILLIGOSS BOULEVARD SOUTHEAST		
FIRST C	ARE LIVING CENTER			F	OSSTON, MN 56542		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	Continued From pa	ige 15	F 6	607			
F 607	to past incidents by policy did not include residents who may. During interview on director of nursing directed staff to reprimmediately if the inotherwise it was 24. At 1:35 p.m. the ad	the alleged perpetrator. The de interviews with other staff or have knowledge of abuse. 7/12/21, at 11:16 a.m. the (DON) stated the policy port to the administrator incident was urgent but hours. ministrator stated the incidents abuse and should have been	F6	807	conducted in response to an incide report also requires interviews with staff or residents who may have knowledge or abuse. Systematic change to ensure compaint with policy: Implementation of First Care Vulne Adult Template: On 7/14 the facility First Care Vulnerable Adult Templatimplemented in response to the sure The DON and/or SSD (as applicable utilize the facility First Care Vulnerable as a checklist to as that applicable interviews of residers at the staff who may have knowledge of and neglect, as well as observation care are included as part of the investigation of potential maltreatm Policy Education: Staff were educated the revised policy on 8/4/21 and 8/5. The new policy and procedure is an in the nurse stations and staff lofor reference. Supplemental Education on Vulneradults: In addition to the existing a training on vulnerable adults, all state actively working, including the DON nursing home staff and staff from of departments (housekeepers, supplemental, lab, therapy, maintenance) completed the assigned training Education by 8/10/21. hires will also receive this supplemental also receive this supplemental and staff received the supplemental competency evaluation by 8/10/21.	other cliance rable / S te was rvey. le) will erable sure nts and abuse s of ent. ted on 5/21. /ailable unge able nnual iff I, ther y lucare ng New ental	
					annual training on a going forward Monitoring/Metrics:		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		COMPLETED			
		245512	B. WING			C 15/2021
	PROVIDER OR SUPPLIER ARE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542		
(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 CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 607	Continued From pa	ge 16	F 6	Monthly Audit: Effective 8/1/21, the will conduct a monthly audit of all grievance forms and SA investiga to identify compliance to the revise Facility S Grievance Policy/Form implemented on 7/14/21. The audindings will be reviewed in the subsequent QAPI committee and will direct any necessary corrective These audits will continue for 6 m which time QAPI will determine if additional audits are necessary. Timely Reporting/Vulnerable Adult Education Audit: in addition, the D designee will conduct random audingenees working on all shifts to timely reporting and understanding Vulnerable Adult policy and proceed the audit schedule will be: 3x/week weeks and then weekly x4 weeks audit will include 5 employees. Reportings. The QAPI committee we findings and determine if additional auditing or corrective action is required.	ON or lits with verify g of the dure. Each sults will ill review al	
	Reporting of Allege CFR(s): 483.12(c)(F 6	Date of Compliance: 8/15/21		8/15/21
		nse to allegations of abuse, n, or mistreatment, the facility				
	involving abuse, ne	re that all alleged violations glect, exploitation or ding injuries of unknown				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 11 20122				
		245512	B. WING			07/1	15/2021
	PROVIDER OR SUPPLIER ARE LIVING CENTER			9	TREET ADDRESS, CITY, STATE, ZIP CODE 00 HILLIGOSS BOULEVARD SOUTHEAST COSSTON, MN 56542		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	are reported immed hours after the alleg that cause the alleg serious bodily injury the events that cau abuse and do not rethe administrator of officials (including the administrator of officials (including the administrator in log accordance with Strocedures. §483.12(c)(4) Repositive statement of the designated represe accordance with Strocedures accordance with	ropriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to f 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	F	609	F 609 Facility, with assistance of outside I counsel review, has implemented the following systemic changes/ measure the deficient practice will not revisions to Facility Grievance Policy/Form and Reporting Education Effective 7/14, the facility grievance has been reviewed and updated with directions to identify the grievance of immediately report the grievance to SSD/DON/RN/or Administrator. The	on: e form th clear and the	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245512	B. WING		07	C / 15/2021
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, Z	· · · · · · · · · · · · · · · · · · ·	710/2021
				900 HILLIGOSS BOULEVARD S		
FIRST C	ARE LIVING CENTER			FOSSTON, MN 56542	JOITILAGI	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 609	ADL's. R2's quarterly MDS was moderately co extensive assitance care plan dated 5/1 mobility related to with directed staff to assitransfers. R4's quarterly MDS was severely cognitotal assistance froplan dated 5/19/21, and impaired mobil with ADL's. R1's significant chaidentified severe coshe required assist and was incontined care plan dated 7/6 Alzheimer's and imdirected staff to assimilar concerns as mean, using profar form indicated registered complaint from a sime mean, using profar form indicated R3 reday shift NA's and interviewed by RN-indicated a night shift NA's and interviewed by RN-indicated and interviewed by RN-indicated she interviewed she inte	S dated 5/4/21, indicated he gnitively impaired and required a from two staff for ADL's. R2's 3/21, identified impaired weakness and pain and sist with bed mobility and S dated 5/11/21, indicated he tively impaired and required m staff for ADL's. R4's care, identified impaired cognition lity and directed staff to assist ange MDS dated 6/16/21, ognitive impairment, indicated ance from two staff for ADL's at of bowel and bladder. R1's 5/21, identified a diagnosis of paired mobility. The care plan	F 6	the grievance form to de grievance concerns pote neglect under the Reside Plan/Vulnerable Adult porocedure, effective July suspicions or abuse or nimmediately notify the Additionally, residents ar representatives were edireport grievances or conresident care, via the we newsletter on 7/15/21, won 8/4/21 and 8/5/21. The provide ongoing educationally and/or representatives do care conferences on the procedure and Resident Implementation of First Care Vulnerable Addimplemented in responsor The DON and/or SSD (autilize the facility spirst Adult Template as a cheef that applicable interviews staff who may have known and neglect, as well as on care are included as par investigation of potential Monthly Audit: Effective 8 will conduct a monthly audit grievance forms and SA to identify compliance to Facility should be reviewed in reviewed.	ential abuse or ent Protection officy and of 12, 2021, and if reglect, will diministrator or will notify the end/or ucated on how to cerns about rekly facility with staff training re SSD/RN will on to residents uring scheduled grievance Bill of Rights. Care Vulnerable the facility se to the survey. It is applicable) will care Vulnerable cklist to assure is of residents and wledge of abuse observations of the maltreatment. B/1/21, the SSD udit of all investigative files the revised licy/Form. The audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	COM	E SURVEY PLETED	
		245512	B. WING _			15/2021
	PROVIDER OR SUPPLIER ARE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP 0 900 HILLIGOSS BOULEVARD SOU FOSSTON, MN 56542	CODE	
(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 CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 609	NA-A identified the From RN-A to NA-A resident c/o [compl 2 small thin girls who being mean and us called her a bitch." A Resident Grievar indicated NA-C repthe DON the follow about the incidents On Saturday night [R4 and R3]'s room ready for bed. Both inappropriate jokes with both residents A facility Resident indicated NA-D repand the administration am sorry to be sent the evening but I juworking my scheduli:30 p.m. and I cabetween another stonator in them with p.m. care During the cares R to NA-A. NA-D did but shortly after NA-D small part of the shortly after NA-D did but shortly after NA-D small part of the shortly after NA-D did but shortly after NA-D small part of the shortly after NA-D did but shortly after NA-D small part of the shortly after NA-D did but	following: 3/7/21, at 7:09 a.m., A; "Hey. We have had a ain of] this morning about the no were in her room last night ing horrible language and ace Form dated 3/8/21, orted in a handwritten note to ing: "I want to inform you that happened this weekend. 3/6, [NA-A and NA-B] were in while I was helping them get girls were making, swearing and being 'rough'." Grievance Form dated 4/5/21, orted via e-mail to the DON for on 4/5/21, at 11:39 p.m.: "I ding you this e-mail so late in st got home from the facility alled shift from 2:00 p.m. to n't sleep with what happened faff and a resident." NA-A and to R3 and R4's room to assist es and into bed for the night. 3 had made some comments not remember all of the details I-A told R3 to "shut the F***	F 60	subsequent QAPI committee will direct any necessary of These audits will continue which time QAPI will determ additional audits are necessary of the compliance: 8/15/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/	orrective action. for 6 months, at mine if ssary.	
	to NA-A. NA-D did but shortly after NA up." Then while ass tone that she was smean to her when them. A facility Resident (indicated licensed)	not remember all of the details				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245512	B. WING		07	C / 15/2021	
	PROVIDER OR SUPPLIED ARE LIVING CENTE			STREET ADDRESS, CITY, STATE, ZIP 900 HILLIGOSS BOULEVARD SOU FOSSTON, MN 56542	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 609	6/19/21, a text methe DON and indicagain last night. L NA's who witness my door to review tonight." An untitle during the evening were assisting R1 had been inconting assist. NA-A enter door and stated "It this F***** stinks NA-A stated R1 "s" why do you have this is ridiculous." F*** up, you're nown A report regarding the SA on 7/6/21, made. During interview of stated the incident weekend. The incident weekend. The incident weekend. The incident working (NA-A and right away and R3 her a B****. "RN-incident to the direct same morning. During interview of DON said the incident to the direct same morning.	essage was sent from RN-B to cated: "FYI, issues with [NA-A] PN-A has statements from two ed her behavior and form under concerns about [NA-A] working ed undated document indicated g of 6/18/21, NA-E and NA-F to wash up for the evening. R1 tent and staff called NA-A to red the room and stood by the Eewwdo I really need to help, so bad." While providing care stinks like shit all the time, " and so much F******* poop on you, NA-A also told R1, "shut the	F	609			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
		245512	B. WING _		07	//15/2021	
	PROVIDER OR SUPPLIER ARE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP O 900 HILLIGOSS BOULEVARD SOU' FOSSTON, MN 56542	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 609	door and was supp DON confirmed the made timely. At 12 had not thought ab to the SA but said, that's why a grievar stated each of the ireported to the SA covering it by filing. At 1:35 p.m. the adfit the definition of a reported to the SA. On 7/15/21, at 10:3 stated he relied on stay abreast of poli not to get too in department of the was involved in reporting and follow acknowledged he was too the same supporting and follow acknowledged he was too the same supporting and follow acknowledged he was too the same supporting and follow acknowledged he was too the same supporting and follow acknowledged he was too the same supporting and follow acknowledged he was too the same supporting and follow acknowledged he was too the same supporting and follow acknowledged he was too the same supporting and follow acknowledged he was too the same supporting and follows.	prosed to investigate it. The experit report to the SA had not been 224 p.m. the DON stated she out the incidents as reportable "it is abuse, I took it seriously," note was completed. The DON incidents should have been and she thought they were a grievance. Imministrator stated the incidents abuse and should have been	F 60	9			
	Adult Policy and Prindicated Essentia establish and enfor prevention plan. Thassessment of the and it's population encourage or perm specific measures risk of abuse. The lass soon as possib from the time initial occurred has been	a Health Fosston Vulnerable ocedure dated June 2017, Health Fosston should oce an ongoing abuse he plan shall contain an physical plant, environment identifying factors which may hit abuse and a statement of to be taken to minimize the policy identified Immediate as: le, but no later than 24 hours knowledge that the incident received." The policy indicated an electronic submission to the					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	COMPLETED
		245512	B. WING _		C 07/15/2021
	PROVIDER OR SUPPLIER ARE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542	,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROPERTION DEFICIENCY)	D BE COMPLÉTION
F 609 F 610 SS=E	incident. Investigate/Prevent CFR(s): 483.12(c)(2) §483.12(c) In responeelect, exploitation must: §483.12(c)(2) Have violations are thorous §483.12(c)(3) Preveneelect, exploitation investigation is in provided in the second and in the second and if the second and	created within 24 hours of the control of the contr	F 60	9	8/15/21
	of abuse and provide investigation for 4 control reviewed for allegated	of 4 residents (R3, R4, R2, R1)		Facility, with assistance of outside counsel review, has implemented following systemic changes/ measensure the deficient practice will re-	the sures to
	indicated registered complaint from a st mean, using profan	Grievance Form dated 3/7/21, I nurse (RN)-A received a aff member of staff being ity and calling R3 a name. The eported similar information to		Corrections: Revisions to Facility Grievance Policy/Form: Effective 7/14, the fa grievance form has been reviewed updated with clear directions to id the grievance and immediately re-	acility d and entify

PRINTED: 08/18/2021 FORM APPROVED OMB NO. 0938-0391

CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES			OI	<u>мв NO.</u>	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	COMI	SURVEY PLETED
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NAME OF F	DOVIDED OF OURDUIED	240012	D: 11110		OTREET ARRESCO CITY OTATE ZIR CORE	071	15/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
FIRST CA	ARE LIVING CENTER				900 HILLIGOSS BOULEVARD SOUTHEAST		
					FOSSTON, MN 56542		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	-	~	F 6	310			
		remained consistent when			grievance to the SSD/DON/RN/or		
		A. The grievance further			Administrator. The applicable person		
	•	ift licensed practical nurse			charge must review the grievance f		
		complaint and R3's family			determine if this grievance concern		
		d and reported R3 had told her			potential abuse or neglect under the		
		nmediate action by nurse riewed R3 and sent messages			Resident Protection Plan/Vulnerabl policy and procedure, effective July		
		asking for their input.			2021, and if suspicions or abuse or		
		ssages between RN-A and			neglect, will immediately notify the		
		following: 3/7/21, at 7:09 a.m.,			Administrator or Director of Nursing	who	
		A; "Hey. We have had a			will notify the Administrator.	,	
		ain of) this morning about the					
		no were in her room last night			Revisions Facility's Resident Protection		
		ing horrible language and			Vulnerable Adult Policy and Proced		
		The report indicated NA-B			On 7/12/21, as part of the IJ remov		
		erself had been in R3's room			the Administrator and DON of the fa		
		nied NA-A swearing at R3 and			replaced the then current Essentia		
		em, "Goodnight Girls, Thank d she may have been			Resident Protection Plan/ Vulnerab policy and procedure dated June 20		
		way but denied it being			with a revised Resident	J17,	
		dents. Interview with R3			Protection/Vulnerable Adult policy a	nd	
		een mixed up and confused			procedure, effective July 12, 2021,		
		. The grievance lacked			better reflect current federal regular		
		er resident or staff who may			The QAPI committee will provide a		
	have had further kn	lowledge and did not identify			review and formal approval of upda		
		es were completed to ensure			policy on 8/12/21.		
		vere received. Further, the					
	O	vidence the residents were			This updated policy and procedure		
	protected from furth	ner abuse, pending			includes the following revisions to b		
	investigation.				reflect current federal reporting and		
	A Resident Crievan	ice Form dated 3/8/21,			protection requirements: (i) require that "immediately or as soon as pos		
		orted in a handwritten note to			reporting to the Administrator & OH		
		ing: "I want to inform you			serious bodily injury or allegations of		
		that happened this weekend.			abuse, no later than 2 hours of form		
		3/6, [NA-A and NA-B] were in			the suspicion or being notified of ar		
		while I was helping them get			allegation" and "within 24 hours of f		
	ready for bed. Both				the suspicion or being notified of ar		

inappropriate jokes, swearing and being rough

allegation if the suspicion or allegation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		SURVEY PLETED
		245512	B. WING				15/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
FIDOT O	ADE I IV/INO OFNITED			9	00 HILLIGOSS BOULEVARD SOUTHEAST		
FIRST C	ARE LIVING CENTER			F	OSSTON, MN 56542		
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
					BEITOLENSTY		
F 610	with both residents. unidentified RN star crabby when giving interviewed and sai issue. The resident something happen mad about everythi resident reported the she is crabby." NAshe was trying to do report lacked evide regarding the allegainterviews with other have had further knobservations of care apporpriate cares we grievance lacked exprotected from furth investigation. A facility Resident indicated NA-D repeated the administration am sorry to be send the evening but I just working my schedu 11:30 p.m. and I cale between another st NA-D had gone into them with p.m. care During the cares R3 to NA-A. NA-D indicated the details but short the F*** up." Then the same care the same care in the p.m. care to NA-A. NA-D indicated the details but short the F*** up." Then the care in the properties of the properties o	"The form indicated an ted NA-B told her R2 was report. Another resident was d she wanted to report an stated NA-A must have had on the way to work, she was ng and in a bad mood. The nat NA-A,"she gets rough if A was interviewed and stated to her job by rolling them. The nace NA-B was interviewed ation. The grievance lacked or resident or staff who may nowledge and did not identify es were completed to ensure were received. Further, the vidence the residents were	F	310	does not involve abuse or did not reserious bodily injury"; (ii) a requirem that "if the alleged perpetrator is state assure that the alleged perpetrator notified of the investigator suspension and remove from the facility pending outcome of the investigation"; and (requirement that any investigation conducted in response to an incide report also requires interviews with staff or residents who may have knowledge or abuse. Systematic Change to ensure investigative steps are taken: Implementation of First Care Vulne Adult Template: On 7/14 the facility Care Vulnerable Adult Template was implemented in response to the sure The DON and/or SSD (as applicable utilize the facility's First Care Vulnerable Adult Template as a checklist to asset that applicable interviews of resident staff who may have knowledge of and neglect, as well as observation care are included as part of the investigation of potential maltreatm. Education on Grievance Policy and Residents and/or representatives we educated on how to report grievance concerns about resident care, via the weekly facility newsletter on 7/15/2 staff training on 8/4/21 and 8/5/21. SSD/RN will provide ongoing educates and/or representatives ducated and/or representatives ducate	rent aff, is is is ion, g iiii) a nt other rable rable rable sure nts and abuse s of ent. Form: vere es or ne 1, with The ation to uring	
	help them. The repowrite a statement a	when she was only trying to ort indicated NA-A "agrees to nd bring it by in a.m." NA-A going on, I have really tried to			scheduled care conferences on the grievance procedure and Resident Rights. Education on Resident Protection /		

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL) 245512 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542 CX4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETICATION (EACH CORRECTIVE ACTION SHOULD BE	STATEMENT O AND PLAN OF	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,			(X3) DATE	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER FIRST CARE LIVING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETICATION SHOULD SHOU			245542					
FIRST CARE LIVING CENTER 900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETICE)		101/IDED OD 01/IDD1/IED	245512	B. WING			07/1	5/2021
FIRST CARE LIVING CENTER FOSSTON, MN 56542 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETI	NAME OF PR	OVIDER OR SUPPLIER						
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETI	FIRST CAF	RE LIVING CENTER						
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	3E	COMPLETION
watch my mouth, you have talked to me before about it and I'm sick of being called to your office." The grievance lacked interviews with other resident or staff who may have had further knowledge and did not identify observations of cares were received. Further, the grievance lacked evidence the residents were protected from further abuse, pending investigation. A facility Resident Grievance Form dated 6/18/21, indicated licensed practical nurse (LPN)-A and NA-E reported NA-A using inappropriate language. The form indicated on Saturday 6/19/21, a text message was sent from RN-B to the DON and indicated: "FLY, issues with [NA-A] again last night. LPN-A has statements from two NA's who witnessed her behavior and form under my door to review concerns about [NA-A] working tonight." An untitled undated document indicated during the evening of 6/18/21, NA-E and NA-F were assisting R1 to wash up for the evening. R1 had been incontinent and staff called NA-A to assist. NA-A entered the room and stood by the door and stated "Eewwdo I really need to help, this F****** why you're not in F***** pin, you're not in F***** pin, you're not in F***** pin, you're not in F***** pin." The grievance lacked interviews with other resident or staff who may have had further knowledge and did not identify observations of cares were cenejued to the pin the province and the facility's updated policy on subresidates allegated and investigation and investigation of potential misconduct in accordance with the law and the facility's updated policy on vulnerable adults and the grievance form process. Monthly Audit: Effective 8/1/21, the SSD will conduct a monthly audit of all grievance Policy/Form implemented on 7/14/21. The audit findings will be required in the province lacked interviews with other resident or staff who may have had further knowledge and did not identify observations of cares were completed to ensure apporpriate cares were completed to ensure apporpriate cares were completed to ensure apporpriate cares were completed to	version of the contract of the	watch my mouth, you about it and I'm sich office." The grievan other resident or standwide ares were complete acked evidence the grown further abuse, and facility Resident Condicated licensed properties. The form further abuse, anguage. The form fo/19/21, a text mestagain last night. LP NA's who witnessed in the DON and indicated licensed properties. The form fo/19/21, a text mestagain last night. LP NA's who witnessed in the evening were assisting R1 to the form form form form form form form form	ou have talked to me before k of being called to your nee lacked interviews with aff who may have had further not identify observations of ted to ensure apporpriate d. Further, the grievance e residents were protected pending investigation. Grievance Form dated 6/18/21, practical nurse (LPN)-A and A using inappropriate in indicated on Saturday sage was sent from RN-B to ated: "FYI, issues with [NA-A] N-A has statements from two d her behavior and form under concerns about [NA-A] working I undated document indicated of 6/18/21, NA-E and NA-F to wash up for the evening. R1 and staff called NA-A to detect the resident of the providing care inks like shit all the time, " and so much F****** poop on you, IA-A also told R1, "shut the in F****** pain." The grievance with other resident or staff who are knowledge and did not as of cares were completed to cares were received. Further, and evidence the residents were	F	310	Staff were educated on this policy or 8/4/21 and 8/5/21. The new policy a procedure is available in the nurse's stations and staff lounge for reference Monitoring/Metrics: Report Log: The facility's SSD implemented the Grievance/ Reports on 8/6/21 to track any reports to the ensure facility appropriately respond investigates allegations of potential misconduct in accordance with the la and the facility's updated policy on vulnerable adults and the grievance process. Monthly Audit: Effective 8/1/21, the Swill conduct a monthly audit of all grievance forms and SA investigative to identify compliance to the revised Facility's Grievance Policy/Form implemented on 7/14/21. The audit findings will be reviewed in the subsequent QAPI committee and Qwill direct any necessary corrective at These audits will continue for 6 mon which time QAPI will determine if additional audits are necessary. Timely Reporting/Vulnerable Adult Education Audit: in addition, the DOI designee will conduct random audits employees working on all shifts to ve timely reporting and understanding of Vulnerable Adult policy and procedur. The audit schedule will be: 3x/week weeks and then weekly x4 weeks. E	s Log SA to Is and aw form SSD e files API action. aths, at N or s with erify of the re. x4 Each	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	LE CONSTRUCTION	COMI	E SURVEY PLETED
		245512	B. WING			C 1 5/2021
	PROVIDER OR SUPPLIER ARE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP O 900 HILLIGOSS BOULEVARD SOU FOSSTON, MN 56542	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 610	administrator stated of abuse and shoul investigated. The I interview stated foll involving R1, NA-A day and with the oth with the residents, nursing assistants working. The DON documented proof language with any of had been taken in not interviewed othe determine if any oth subjected to verbal completed observa investigative process. The facility Essentia Adult Policy and Pridentified - Section V, Report and Facility Resport Investigation indicate immediately to the policy directed once a team will convene investigation. The instaff involved in the plan was needed at to past incidents by policy did not include interviews to the policy did not include the polic	d the incidents fit the definition d have been thoroughly DON, present during the owing the last incident had been suspended the next her incidents she had spoken with the previous incidents the were allowed to continue stated there was no NA-B had used inappropriate of the residents so no action regard to NA-B. The DON had her residents or staff to her residents had been abuse by NA-A or NA-B or tion of cares as part of the ss. The Health Fosston Vulnerable occedure dated June 2017, hing of Incident, Investigation has to the Results Of the ted reports would be made director of long term care. The sea a report was made internally, and the internal team should interview incident, decide if a safety and gather information related the alleged perpetrator. The le interviews with other staff or have knowledge of abuse	F 610	meetings. The QAPI comm findings and determine if ac auditing or corrective action. Date of Compliance: 8/15/2	dditional n is required.	



Electronically delivered August 3, 2021

Administrator
First Care Living Center
900 Hilligoss Boulevard Southeast
Fosston, MN 56542

Re: State Nursing Home Licensing Orders

Event ID: DJIC11

Dear Administrator:

The above facility was surveyed on July 12, 2021 through July 15, 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 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:

Jen Bahr, RN, Unit Supervisor Bemidji District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 705 5th Street NW, Suite A Bemidji, MN 56601-2933

Email: Jennifer.bahr@state.mn.us

Office: (218) 308-2104 Mobile: (218) 368-3683

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

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		E SURVEY PLETED
		00461	B. WING		l l	C 15/2021
					1 011	13/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FIRST C	ARE LIVING CENTER	****	GOSS BOUL I, MN 56542	EVARD SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficient herein are not corrected shall with a schedule of the Minnesota Department					
	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 compliance with all a rule provided at the tagule number indicated below. In several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ament of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	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.				
	conducted at your f Minnesota Departm facility was found N State Licensure. Pla plan of correction you and identify the date	TS: 11, a complaint survey was facility by surveyors from the nent of Health (MDH). Your OT in compliance with the MN ease indicate in your electronic ou have reviewed these orders e when they will be completed.				
	epartment of Health Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE

Electronically Signed 08/11/21

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COME	SURVEY PLETED
			A. BOILDING.			С
		00461	B. WING			15/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FIRST C	ARE LIVING CENTER		GOSS BOUL I, MN 56542	LEVARD SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 000	Continued From pa	age 1	2 000			
	SUBSTANTIATED: a licensing order is 626.557 Subd. 4A The following compuNSUBSTANTIAT Minnesota Department the State Licensing Federal software. The state states of the state states of the state states of the correction order the findings which statute after the states of the Suggested.	plaint was found to be the H5512038C (MN74548) with sued at MN St. Statute as a result of the investigation. Plaint was found to be ED: H5513039C (MN74696). The ment of Health is documenting a Correction Orders using a numbers have been sota state statutes/rules for the assigned tag number eff column entitled "ID Prefix atute/rule out of compliance is the "To Comply" portion of the state attement, "This Rule is not met collowing the surveyor's findings Method of Correction and				
	receipt of State lice the Minnesota Dep Informational Bulle https://www.health. n/infobulletins/ib14 orders are delineat Department of Hea you electronically. is necessary for St enter the word "CC available for text. Y electronic State lice heading completion	o participate in the electronic ensure orders consistent with				

Minnesota Department of Health

STATE FORM DJIC11 If continuation sheet 2 of 8

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00461	B. WING		07/1	5/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FIRST C	ARE LIVING CENTER		GOSS BOUL I, MN 56542	LEVARD SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	the Minnesota Depais enrolled in ePOC	artment of Health. The facility and therefore a signature is bottom of the first page of				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE N WHICH STATES, IN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
21995	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 4a Reporting - Inerable Adults	21995			8/15/21
	(a) Each facility shongoing written proapplicable licensing of suspected maltrefacility has an intermandated reporter requirements of this internally. However	I reporting of maltreatment. all establish and enforce an ocedure in compliance with rules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting section by reporting r, the facility remains applying with the immediate ents of this section.				
	by: Based on interview facility failed to report administrator and Stresidents (R3, R2,	and document review the ort incidents of abuse to the state Agency (SA) for 3 of 3 R4) and failed to report timely resident (R1) reviewed for		Corrected		
	Findings include:					
		mum Data Set (MDS) dated ne had intact cognition and				

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Minnesota Department of Health STATE FORM

Millinesc	ita Department of He	aitii				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00461	B. WING			5/2021
NAME OF		CTDEET ADI		STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FIRST C	ARE LIVING CENTER			LEVARD SOUTHEAST		
		FOSSION	I, MN 56542			
(X4) ID	_	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION SHOULD		(X5) COMPLETE
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		DATE
		,	.,	DEFICIENCY)		
21005	Continued From no	ao 3	21995			
21995	Continued From pa	ge 3	21995			
	required supervision to complete activities of dail					
	living (ADL)'s. R3's	care plan dated 4/20/21,				
		of Alzheimer's and dementia.				
	•	ified decreased independence				
		ance from staff to perform				
	ADL's.					
		dated 5/4/21, indicated he				
		gnitively impaired and required				
		e from two staff for ADL's. R2's				
		3/21, identified impaired				
		veakness and pain and sist with bed mobility and				
	transfers.	sist with bed mobility and				
	uansiers.					
	R4's quarterly MDS	dated 5/11/21, indicated he				
		tively impaired and required				
		n staff for ADL's. R4's care				
		identified impaired cognition				
		ity and directed staff to assist				
	with ADL's.					
	R1's significant cha	nge MDS dated 6/16/21,				
		gnitive impairment, indicated				
		ance from two staff for ADL's				
		t of bowel and bladder. R1's				
	•	/21, identified a diagnosis of				
		paired mobility. The care plan				
	directed staff to ass	sist with all ADL's.				
	A facility Danidant C	Priovance Form dated 2/7/24				
		Grievance Form dated 3/7/21, I nurse (RN)-A received a				
		aff member of staff being				
		ity and calling R3 a name. The				
		eported similar information to				
		remained consistent when				
		A. The grievance further				
		ift licensed practical nurse				
		complaint and R3's family				
		d and reported R3 had told her				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
			A. BUILDING.		,	C
		00461	B. WING		I	15/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FIRST C	ARE LIVING CENTER		GOSS BOUL I, MN 56542	EVARD SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21995	similar concerns. Ir indicated she intervolve to NA-A and NA-B Correlating text ments on NA-A identified the From RN-A to NA-A resident c/o [comploing mean and us called her a bitch." A Resident Grievar indicated NA-C repute DON the follow about the incidents On Saturday night [R4 and R3]'s room ready for bed. Both inappropriate jokes with both residents. A facility Resident indicated NA-D repute and the administration am sorry to be senting the evening but I just working my schedult:30 p.m. and I cabetween another sind NA-D had gone into them with p.m. care During the cares R to NA-A. NA-D did but shortly after NA up." Then while assistent to her when them.	mmediate action by the nurse viewed R3 and sent messages asking for their input. It is sages between RN-A and following: 3/7/21, at 7:09 a.m., A; "Hey. We have had a ain of] this morning about the no were in her room last night sing horrible language and the following: "I want to inform you that happened this weekend. 3/6, [NA-A and NA-B] were in a while I was helping them get a girls were making s, swearing and being 'rough'	21995			

6899

Minnesota Department of Health STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
			71. BOILDING.			С
		00461	B. WING			15/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FIRST C	ARE LIVING CENTER		GOSS BOUL I, MN 56542	LEVARD SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21995	indicated licensed in NA-E reported NA-language. The form 6/19/21, a text mess the DON and indicated again last night. LP NA's who witnessed my door to review of tonight." An untitled during the evening were assisting R1 to had been incontine assist. NA-A entered door and stated "Edithis F****** stinks son NA-A stated R1 "still "why do you have so this is ridiculous." NE*** up, you're not in the SA on 7/6/21, 1 made. During interview on stated the incident weekend. The incident weekend. The incident weekend. The incident working (NA-A and right away and R3 in her a B****. "RN-A incident to the direct same morning. During interview on stated the incident to the direct same morning.	practical nurse (LPN)-A and A using inappropriate in indicated on Saturday sage was sent from RN-B to lated: "FYI, issues with [NA-A] N-A has statements from two done her behavior and form under concerns about [NA-A] working a undated document indicated of 6/18/21, NA-E and NA-F to wash up for the evening. R1 and staff called NA-A to led the room and stood by the lewwdo I really need to help, to bad." While providing care links like shit all the time, " and so much F******* poop on you, IA-A also told R1, "shut the	21995			
		was important and that's why a as filed. Further, she started				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00461	B. WING		07/1	5/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FIRST C	ARE LIVING CENTER		GOSS BOUL I, MN 56542	EVARD SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21995	the grievance process notified the grievance door and was supp DON confirmed the made timely. At 12th had not thought about to the SA but said, that's why a grievar stated each of the ireported to the SA covering it by filling. At 1:35 p.m. the adfit the definition of a reported to the SA. On 7/15/21, at 10:3 stated he relied on stay abreast of polinot to get too in depadministrator stated he was involved in reporting and follow acknowledged he wimmediately when if facility. The facility Essentia establish and enfor prevention plan. The sessment of the and it's population in encourage or permispecific measures in risk of abuse. The masses in the limit is soon as possibly from the time initial	ess on 6/21/21, when she was ce had been placed under her osed to investigate it. The export to the SA had not been 24 p.m. the DON stated she out the incidents as reportable "it is abuse, I took it seriously," nee was completed. The DON incidents should have been and she thought they were a grievance. ministrator stated the incidents abuse and should have been	21995			

Minnesota Department of Health

STATEMENT OF O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			,
		00461	B. WING			5/2021
NAME OF PRO	VIDER OR SUPPLIER			STATE, ZIP CODE		
FIRST CARE	E LIVING CENTER		GOSS BOUL , MN 56542	LEVARD SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21995 Co	ontinued From pag	ge 7	21995			
SA		n electronic submission to the ted within 24 hours of the				
SU ad po of ap sh po of tim to Im	JGGESTED MET Iministrator or des plicies or procedur all allegations of a propriate timefran could re-educate s plicies and procedualleged abuse or ne. The results of the Quality Assura provement (QAP)	HOD OF CORRECTION: The signee could develop/revise es 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 ance Performance. I) committee to determine the nitoring or compliance. R CORRECTION: 21 DAYS				

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