Electronically delivered
September 12, 2022

Administrator
MN Veterans Home Fergus Falls
1821 North Park
Fergus Falls, MN 56537

RE: CCN: 245636
Cycle Start Date: August 31, 2022

Dear Administrator:

On August 31, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 1, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 1, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245636	A. BUILDING _____ B. WING _____	C 08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME FERGUS FALLS	1821 NORTH PARK FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/30/22 - 8/31/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H56364324C (MN86272), however NO deficiencies were cited due to actions implemented by the facility prior to survey. As a result of the survey related efficiencies were cited at F609 and F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown	F 609		9/30/22

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

Electronically Signed | 09/20/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 609	Continued From page 1 source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to report to the state agency (SA) an injury of unknown origin alleged to be caused during transfer with a mechanical lift for 1 of 3 resident reviewed for neglect of care. Findings include: R2's quarterly Minimum Data Set dated 5/20/22, indicated moderate cognitive impairment. A facility incident report dated 8/11/22, indicated R2 had an appointment at the wound clinic on 8/11/22, and reported at the appointment that his left ankle hurt and that he had injured it in a Hoyer lift (mechanical lift). The incident report was	F 609	1. Investigated R2's incident on 8/17/2022. R2 continues to see Lake Region wound care. Provided education to all nursing staff on what is reportable and to whom to report to. The education was provided on 9/2/2022 and all nursing staff that missed the training must read the power point slides and attached notes, sign and date the signature page. 2. Any resident has the potential to have an incident that does not get reported to OHFC. 3. IDT team will review the 24-hour and	

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F 609	Continued From page 2 updated on 8/29/22, and indicated R2's medical record was reviewed and there was no noted incident in which he had an injury while using the ceiling lift. An untitled provider note dated 8/15/22, indicated R2 was being treated at care center for left lower extremity ulcerations and had been complaining of pain to the medial left ankle for approximately four weeks. R2 reported an injury to his ankle involving his Hoyer lift. Staff at the care center were consulted and were not aware of any injury. Exam consistent with a ligament sprain. Plan: wear Tri-lock brace on ankle daily for three weeks, remove to perform range of motion. Recommend icing ankle and taking anti-inflammatory medication, elevate ankle and wear compression garment to help reduce swelling. R2's facility Progress Notes revealed the following: 7/5/22, R2 told writer that "the day before yesterday" he was lifted up in the ceiling lift and his left leg was twisted. R2 reported his leg hurt from hip to ankle and requested to speak to the unit coordinator. The note indicated the shift supervisor was notified. Record review lacked evidence of an investigation following R2's report of injury from the ceiling lift. 8/11/22, R2 went out to physician for wound care. Left ankle exam performed due to complaint of Hoyer injury to the ankle. X-ray to left ankle completed in reference to "ankle related injury to Hoyer lift."	F 609	72-hour reports and cross reference with incident reports to ensure all incidents that should be reported to OHFC, are reported. Education was provided to all nursing staff on 9/2/2022 focused on reporting incidents to OHFC. Licensed staff was educated on the types of possible reportable events and directed to call Administrator or Director of Nursing to discuss these events as soon as they are discovered. All nursing staff that missed the training must read the power point slides and attached notes, sign and date the signature page. 4. The Director of nursing, Administrator, or other interdisciplinary team members read the 24-hour report in PCC Tuesday-Friday and the 72-hour report on Monday. They will cross reference that with incident reports as well as high alert notes to ensure all incidents that should be reported, are reported.	

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F 609	Continued From page 3 8/12/22, Wound clinic called to report results of left ankle x-ray. X-ray did not reveal any fractures or other acute bony abnormalities. There was some soft tissue swelling which correlated with where R2 was having pain and may be indicative of a medial ankle sprain. 8/17/22, Writer received call from wound center on 8/15/22, indicating a recommendation for an ankle brace to R2's left ankle due to reports of pain from R2 at his last appointment and suspected sprain to left ankle diagnosis. During interview on 8/31/22, at 1:37 p.m. the director of nursing (DON) stated after R2 reported getting hurt on the lift (referring to the 8/11/22 progress note), the team "combed back through the charting" for an incident in the lift and there was nothing. At 1:45 p.m. the DON stated if injuries were reported they looked at things like if the injury was in a suspicious area, does the resident feel safe, does the resident know what happened or if there was a reasonable explanation for the injury. The DON state ultimately it was up to herself and the administrator to determine and an injury of unknown origin was reportable. The DON stated they felt R2's incident was not reportable based on the fact that there was no no visible injury, even though the medical record lacked evidence an assessment of the injury was completed when R2 first made the report on 7/5/22. The DON further stated she and the administrator had talked through it and did not believe it was credible due to R2's cognition. Facility policy titled Vulnerable Adult/Resident Protection Plan dated 7/2/21, identified an injury	F 609		

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F 609	Continued From page 4 of unknown origin as an injury in which the source of the injury was not observed by any person or the source of the injury could not be explained. The policy indicated abuse allegations, including injuries of unknown source were reported per state and federal law.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to investigate an injury of unknown origin for 1 of 3 residents reviewed for neglect of care. Findings include: R2's quarterly Minimum Data Set dated 5/20/22, identified moderate cognitive impairment and	F 610	1. DON interviewed R2's foot regarding the incident and assessed his foot on 9/2/2022. R2 continues to see Lake Region wound care. Education was provided to all nursing staff on 9/19/2022 focused on investigating incidents. All nursing staff not in attendance for the 9/19/2022 meeting must read the power point, sign and date the signature page.	9/30/22

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F 610	Continued From page 5 indicated he required extensive assistance to transfer. R2's care plan dated 6/14/22, indicated impaired mobility related to weakness and gait instability. The care plan directed staff to transfer R2 using a ceiling lift. A facility incident report dated 8/11/22, indicated R2 had an appointment at the wound clinic on 8/11/22, and reported at the appointment that his left ankle hurt and that he had injured it in a Hoyer lift (mechanical lift). The incident report was updated on 8/29/22, and indicated R2's medical record was reviewed and there was no noted incident in which he had an injury while using the ceiling lift. The report indicated R2 was not an accurate historian of events, especially details. An untitled provider note dated 8/15/22, indicated R2 was being treated at care center for left lower extremity ulcerations and had been complaining of pain to the medial left ankle for approximately four weeks. R2 reported an injury to his ankle involving his Hoyer lift. Staff at the care center were consulted and were not aware of any injury. Exam consistent with a ligament sprain. Plan: wear Tri-lock brace on ankle daily for three weeks, remove to perform range of motion. Recommend icing ankle and taking anti-inflammatory medication, elevate ankle and wear compression garment to help reduce swelling. R2's facility Progress Notes revealed the following: 7/5/22, R2 told writer that "the day before yesterday" he was lifted up in the ceiling lift and his left leg was twisted. R2 reported his leg hurt from hip to ankle and requested to speak to the	F 610	2. Any resident has the potential to have an incident that is not investigated thoroughly. 3. IDT team will review the 24-hour and 72-hour reports and cross reference with incident reports to ensure all incidents are investigated thoroughly. Education was provided to all nursing staff on 9/19/2022 focused on investigating incidents in the moment and to call the Administrator or DON for further direction. All nursing staff not in attendance for the 9/19/2022 meeting must read the power point, sign and date the signature page. 4. The Director of nursing, Administrator, or other interdisciplinary team members read the 24-hour report in PCC Tuesday-Friday and the 72-hour report on Monday. They will cross reference that with incident reports as well as high alert notes to ensure all incidents that should be investigated further.	

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F 610	Continued From page 6 unit coordinator. The note indicated the shift supervisor was notified. Record review lacked evidence of an investigation following R2's report of injury from the ceiling lift. 8/11/22, R2 went out to physician for wound care. Left ankle exam performed due to complaint of Hoyer injury to the ankle. X-ray to left ankle completed in reference to "ankle related injury to Hoyer lift," He does not use a Hoyer lift, utilizes ceiling lift which legs/feet are not involved. He has dementia diagnosis and can be very convincing in conversation with non familiar acquaintances. Documentation was reviewed and no documentation found about an incident of pain or bumping his ankle/feet during a transfer. 8/12/22, Wound clinic called to report results of left ankle x-ray. X-ray did not reveal any fractures or other acute bony abnormalities. There was some soft tissue swelling which correlated with where R2 was having pain and may be indicative of a medial ankle sprain. 8/17/22, Writer received call from wound center on 8/15/22, indicating a recommendation for an ankle brace to R2's left ankle due to reports of pain from R2 at his last appointment and suspected sprain to left ankle diagnosis. During interview on 8/31/22, at 1:37 p.m. the director of nursing (DON) stated after R2 reported getting hurt on the lift (referring to the 8/11/22 progress note), the team "combed back through the charting" for an incident in the lift and there was nothing. The DON stated R2 used a ceiling lift and not a Hoyer but acknowledged the lift was	F 610		

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F 610	Continued From page 7 used in and out of the tub which could have involved his feet and legs. The DON stated when the dictation came back from the physician it said R2 had been complaining of this for four weeks. The DON further stated R2 was not an accurate historian. Review of R2's care plan did not reveal a history of or reasons for current deficits/concerns related R2's ability to accurately report abuse, medical conditions or injuries. On 8/31/22, at 2:11 p.m. registered nurse (RN)-A stated she was part of the follow up related to the injury report dated 8/11/22. RN-A stated after speaking with the DON regarding the concern, she went through her e-mails and saw she had been notified that R2 reported an injury in the ceiling lift on 7/5/22. RN-A stated while she had no documentation, she was sure she would have followed up with R2. Facility policy titled Vulnerable Adult/Resident Protection Plan dated 7/2/21, identified an injury of unknown origin as an injury in which the source of the injury was not observed by any person or the source of the injury could not be explained. The policy directed all reports of abuse, neglect.....injuries of unknown origin to be promptly and thoroughly investigated.	F 610		

Electronically delivered
September 12, 2022

Administrator
MN Veterans Home Fergus Falls
1821 North Park
Fergus Falls, MN 56537

Re: State Nursing Home Licensing Orders
Event ID: QS8L11

Dear Administrator:

The above facility was surveyed on August 30, 2022 through August 31, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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	00531	A. BUILDING: _____ B. WING _____	C 08/31/2022

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MN VETERANS HOME FERGUS FALLS	1821 NORTH PARK FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/30/22 - 8/31/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H56364324C (MN86272) with no licensing order issued however, a related licensing order was issued at 1980. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement	21980		9/30/22

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21980	Continued From page 3 agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to report to the state agency (SA) an injury of unknown origin alleged to be caused during transfer with a mechanical lift for 1 of 3 resident reviewed for neglect of care. Findings include: R2's quarterly Minimum Data Set dated 5/20/22, indicated moderate cognitive impairment. A facility incident report dated 8/11/22, indicated R2 had an appointment at the wound clinic on 8/11/22, and reported at the appointment that his left ankle hurt and that he had injured it in a Hoyer lift (mechanical lift). The incident report was updated on 8/29/22, and indicated R2's medical record was reviewed and there was no noted	21980	Corrected	

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21980	Continued From page 4 incident in which he had an injury while using the ceiling lift. An untitled provider note dated 8/15/22, indicated R2 was being treated at care center for left lower extremity ulcerations and had been complaining of pain to the medial left ankle for approximately four weeks. R2 reported an injury to his ankle involving his Hoyer lift. Staff at the care center were consulted and were not aware of any injury. Exam consistent with a ligament sprain. Plan: wear Tri-lock brace on ankle daily for three weeks, remove to perform range of motion. Recommend icing ankle and taking anti-inflammatory medication, elevate ankle and wear compression garment to help reduce swelling. R2's facility Progress Notes revealed the following: 7/5/22, R2 told writer that "the day before yesterday" he was lifted up in the ceiling lift and his left leg was twisted. R2 reported his leg hurt from hip to ankle and requested to speak to the unit coordinator. The note indicated the shift supervisor was notified. Record review lacked evidence of an investigation following R2's report of injury from the ceiling lift. 8/11/22, R2 went out to physician for wound care. Left ankle exam performed due to complaint of Hoyer injury to the ankle. X-ray to left ankle completed in reference to "ankle related injury to Hoyer lift." 8/12/22, Wound clinic called to report results of left ankle x-ray. X-ray did not reveal any fractures	21980		

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21980	Continued From page 5 or other acute bony abnormalities. There was some soft tissue swelling which correlated with where R2 was having pain and may be indicative of a medial ankle sprain. 8/17/22, Writer received call from wound center on 8/15/22, indicating a recommendation for an ankle brace to R2's left ankle due to reports of pain from R2 at his last appointment and suspected sprain to left ankle diagnosis. During interview on 8/31/22, at 1:37 p.m. the director of nursing (DON) stated after R2 reported getting hurt on the lift (referring to the 8/11/22 progress note), the team "combed back through the charting" for an incident in the lift and there was nothing. At 1:45 p.m. the DON stated if injuries were reported they looked at things like if the injury was in a suspicious area, does the resident feel safe, does the resident know what happened or if there was a reasonable explanation for the injury. The DON state ultimately it was up to herself and the administrator to determine and an injury of unknown origin was reportable. The DON stated they felt R2's incident was not reportable based on the fact that there was no no visible injury, even though the medical record lacked evidence an assessment of the injury was completed when R2 first made the report on 7/5/22. The DON further stated she and the administrator had talked through it and did not believe it was credible due to R2's cognition. Facility policy titled Vulnerable Adult/Resident Protection Plan dated 7/2/21, identified an injury of unknown origin as an injury in which the source of the injury was not observed by any person or the source of the injury could not be explained. The policy indicated abuse allegations, including	21980		

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21980	Continued From page 6 injuries of unknown source were reported per state and federal law. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility could re-educate staff to policies and procedures, and audit all complaints of alleged abuse or neglect in a measurable and specific way. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. Those audits should be ongoing and random after compliance is determined by QAPI to ensure compliance is being maintained. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		