

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 31, 2020

Administrator Norris Square 6993 80th Street South Cottage Grove, MN 55016

RE: CCN: 245637

Cycle Start Date: June 11, 2020

Dear Administrator:

On June 30, 2020, we informed you that we may impose enforcement remedies.

On July 15, 2020, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. 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. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On July 15, 2020, the situation of immediate jeopardy to potential health and safety cited at F389 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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(ies) 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 15, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 15, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 15, 2020.

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.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

• Civil money penalty. (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires 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 § 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, Norris Square is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 15, 2020. 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 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:

Karen Aldinger, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900

Email: karen.aldinger@state.mn.us

Phone: (651) 201-3794 Mobile: (320) 249-2805

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 - Health Regulation Division 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 December 11, 2020 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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

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.

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

Kumalu Fiske Downing

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 07/31/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUC		(X3) DAT COM	E SURVEY IPLETED
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NAME OF	PROVIDER OR SUPPLIER	1	<u>'</u>	STREET ADDR	RESS, CITY, STATE, ZIP CODE		10/2020
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	31/16-	TO THE PARTY OF THE PROPERTY O	n WIM.	Care C	Ceter Administrator	ð	(X6) DATE 7/2029

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.

OTATEMENT	OF DESIGNATES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLI	E CONSTRUCTION	(X3) DATE SURVEY	
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F 000	Continued From pa		F	000	Resident R1 was hospitalized of	չը	
	be used as verifica	tion of compliance.			7/2/2020 after incident and cho		•
		table electronic BOC on			not to return to facility. The fa		•
	Upon receipt of an	acceptable electronic POC, an our facility may be conducted to			initiated education on 7/7/20 at		
	validate that subst	antial compliance with the			7/14/20 for the lack of removal	- 1	
	regulations has be	en attained in accordance with			items of harm from R1's room		
	your verification.				notification procedure per police		,
F 689	Free of Accident H	azards/Supervision/Devices	F	689	situations where self-harm or	Jy IOI	
SS=J			ļ		suicidal ideation are present.		
					suicidai ideación are present.		
	§483.25(d) Accide	nts.			A facility audit of PHQ9 score	se sveje	,
	The facility must e	resident environment remains			completed on 7/13/20 to identi		
•	las free of accident	hazards as is possible; and	İ	ļ	other residents that may be at r		
	1				for threats to self-harm. A	1812	
	§483.25(d)(2)Each	resident receives adequate			comprehensive assessment wil	1 ha	
	supervision and as	ssistance devices to prevent			completed on any resident that		
	accidents.				found to be at risk and interven		
		NT is not met as evidenced			implemented and care planned		
	by:	w and document review, the		-	policy.	per .	, age -
	facility failed to con	nplete a psychosocial			poncy.		
	Lassessment, imple	ement safety measures, and			All residents are assessed for s	law of	
	notify appropriate	parties for 1 of 1 residents (R1)			depression via the PHQ9 asses		
	who stated she wa	inted to kill herself with scissors			1		
	she had in her pos	session, then cut her wrists			upon admission, quarterly and		
	with a butter knife	and was transported to the			a significant change in status.		
	hospital. The lack	of facility assessment and			residents are reviewed daily at		
	implementation of immediate jeopard	safety measure, placed R1 in			and any changes in the plan of	care	
	minediate Jeopard				are determined.		
,	The immediate led	pardy began on 7/1/20, at 5:00					,
	p.m. when the faci	ility failed to assess R1's			: .		
	psychological nee	ds, and implement immediate					
İ	safety measures a	ifter R1 threatened to kill					
1	herself with a scis	sors. The administrator and					
	director of nursing	(DON) were notified of the					1
1	I immediate ieopard	ly (IJ) on 7/14/20 at 4:00 p.m.					1

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		•••	*** * *		Ongoing audits are being com		T
F 689			F 68	39	on the residents who trigger for		
		d on 7/15/20, at 11:38 a.m. but	-		threat to self harm on the PHC		v
		ained at the lower scope and			and for those that exhibit state		
		- isolated incident with no			or actions that may indicate a		
		tential for more than minimal			to self harm weekly for 6 wee	ks and	
	harm.				the results will be reported to	the	
	Findings include:				QA Committee to ensure ongo	oing	
	r trianings intolacor				compliance.		
	R1's entry Minimum	Data Set (MDS), dated					
		admission from the			Upon hire, all staff will receiv	re	
		0. R1's MDS, dated 7/2/20,			education on the Threats to Se		
		en discharged to a hospital on			Harm and Prevention Policy a		
	7/2/20.				Guidelines as part of their		±
	виц даа Мал даа.	4.7/4/00 instruded III become			orientation and be completed	hefore	
	alteration in mood o	d-7/1/20, included, "I have an robehavioral expression." R1's			working directly with resident	'e	
		ionstrate effective coping			Audits have been completed t		
		view date." R1's interventions		1	verify understand of the policy		•
		urage me to participate in			expectations on the Threats to		
		Explain all procedures to me.		ľ	Harm policy and continues to		
	Intervene as necess	ary to protect the rights of			ongoing Random audits will	De	
		peak in a calm manner.Divert				1	•
		ne from the situation and take		ŀ	continue for the next 4 weeks		
		ocation as needed." The care			the results will be reported to	- 1	
-		s of anxiety disorder and on with vision loss in both			QA committee to ensure ongo	ıng	
	_	dit, dated 7/1/20, indicated R1			compliance.		
		atches, cuts or skin tears.			7		
-		for Mental Status, Delirium			Date of compliance is 8/9/202	0.	
		assessment, dated 7/2/20,					
		oderately impaired cognition.					
		dated 7/2/20, at 2:30 p.m.					
		Services Director entered					
		nd 2:30 pm to do initial					
		ent admitted to this facility on]	
		radio with her lunch in front				ļ	
		Resident Services Director				İ	

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COM	e survey Pleted C
		245637	B, WING			_07/	15/2020
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F 689	lunch. Writer kep started talking with over her right wrist the knife. There we wrist and started to Writer asked what started to cry. Writer asked what started to cry. Writer and resident Resident then stated to cry. Writer and resident Resident then stated to cry. Writer and resident for a Director informed on 1:1 [one on on made. Resident a abrasions to right Family updated at transferred to Uni [emergency medi provided to this fared admitted there was of resident trying admitted to this fared concerns with selindications that reinvestigation start. R1's progress not indicated R1 was the shift and want away. The progres pretended to take hide medication in about the risk of relevant resident risk of relevant resident risk of relevant resident risk of relevant resident risk of relevant resident risk of relevant resident risk of relevant resident risk of relevant resident risk of relevant resident risk of relevant resident risk of relevant resident risk of relevant resident risk of relevant resident risk of relevant resident risk of relevant resident risk risk of relevant resident risk risk risk risk risk risk risk risk	ras holding a butter knife from than eye on it, and as writer in resident, res [resident] turned than started cutting herself with resident and started cutting herself with resident and resident and resident resident and resident asked if she could have the chanded it over right away. The ted, 'I just want to die.' Resident ayed with resident and texted assistance. Resident Service by nursing to stay with resident e] until a safe plan could be assessed and had superficial wrist. NP [nurse practitioner], and 911 called. Resident ted Hospital via EMT cal transport]. Information acility prior to resident being as no indication of prior attempts to harm self. After resident acility she did not voice any fharm and there were no resident would self harm. Internal and and all parties notified." The dated 7/2/20, at 1:07 a.m. agitated and restless early in the dated 7/2/20, at 1:07 a.m. agitated and restless early in the dated 7/2/20, at 1:07 a.m. agitated and restless early in the dated 7/2/20, at 1:07 a.m. agitated and restless early in the dated 7/2/20, at 1:07 a.m. agitated and restless early in the dated 7/2/20, at 1:07 a.m. agitated and restless early in the dated 7/2/20, at 1:07 a.m. agitated and restless early in the dated 7/2/20, at 1:07 a.m. agitated and restless early in the dated 7/2/20, at 1:07 a.m. agitated and restless early in the dated 7/2/20, at 1:07 a.m. agitated and restless early in the dated 7/2/20, at 1:07 a.m. agitated and restless early in the formal for the further indicated R1 and the further indicated R1 and the further indicated R1 and the further indicated R1 and the further indicated R1 and the further indicated R1 and the further indicated R1 and the further indicated R1 and the further indicated R1 and the further indicated R1 and the further indicated R1 and the further indicated R1 and the further indicated R1 and the further indicated R1 and the further indicated R1 and the further indicated R1 and the further indicated R1 and the further indicated R1 and the further indicated R1 an		689			
	medication or sou	urce of her agitation. te dated 7/2/20, at 8:09 a.m.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245637	B. WING			1	C 15/2020
	PROVIDER OR SUPPLIER			6	TREET ADDRESS, CITY, STATE, ZIP CODE 993 80TH STREET SOUTH COTTAGE GROVE, MN 55016	<u>, 077</u>	13/2020
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F 689	included, "Yelling or approached resider helped. Resident ha oxygen and her rad twisted. Resident ha As writer approached direction of writer. Very cane from hitting writer untangled all room, placed 02 [ox Offered PRN [as nebut resident refused medications but researly for that. Was to "Why are you guys say "I know you're gwriter to call family to [F-A] and left reside writer would be backmorning medication an assessment of R1's progress note included, "Continued the staff are going to that staff was not go was safe." The progress note included, "Nurse magoing to the hospita to cut herself with a wrist. All sharp objeplaced in nurse mar R1's progress note of R1's progress	at taking off her oxygen. Writer at to see how she could be ad her phone, her call light her io all in her left hand with lines ad walking cane in right hand. It resident swung cane in Writer grabbed cane to stop iter. Resident stated that she riter and began to calm down. The cords and organized aygen] back on resident. It was too hen-making statements like, so nice to me?' but then would oing to kill me.' Then asked member [F-A]. Writer called ant alone, letting her know that after breakfast for her s." The note failed to include at distress. I the cause she was seen trying knife." "No puncture noted to cts collected from room and	F	6889			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	FIPLE CONSTRUCTION NG	COM	E SURVEY IPLETED
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F 689	"Writer entered roassessments. Re listening to her racuntouched. Writer her knife from lun as writer started to [resident] turned coutting herself with red mark on her whad been doing throom. Writer aske resident started to have the knife an away. Resident the [family member] is and make things I'm blind. I can't do [family member] is Writer told resident talked a has a lot on [famil member] is responsember] as well. member] takes enthat she broke her [family member and waresident that staff Resident also told because she can Resident stated place to kill herse she has done sor writer not to say a wrist. Writer explanursing staff so the will be going to the started of the sold of t	page 5 bom around 2:30 pm to do initial sident was sitting in her chair dio with her lunch in front of her, noticed resident was holding ch. Writer kept an eye on it, and alking with resident, resover her right wrist and started hethe knife. There was already a wrist, making it appear that she his prior to writer entering her ed what she was doing, and ory. Writer asked If she could dresident handed it over right hen stated: 'I just want to die. My says that I lie. That I just sit here up, but I don't. I don't do that, or anything. I'm better off dead. Dlames me for everything.' In that she was here to listen, about how her [family member] by member's] plate as [family nsible for a [another family Resident stated, 'my [family verything out on me.' She stated in phone after the phone call with er] earlier this afternoon. She have done that. Now I don't have so very tearful. Writer reassured can get her a new phone. If writer that she is scared it see, and she has anxiety, she does not have a plan in lift, and that this is the first time mething like this. She asked anything to anyone about her ained that she has to tell the new can help her and that she e hospital, as 911 was already with resident talking with her		89		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION		E SURVEY IPLETED
		245637	B. WING	·			C 15/2020
	PROVIDER OR SUPPLIER SQUARE			6	TREET ADDRESS, CITY, STATE, ZIP CODE 993 80TH STREET SOUTH COTTAGE GROVE, MN 55016	1 011	13/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	until ambulance arr hospital. She had s during that time, fro [family member] an very tearful and ups conversation she had	ived to take her to the ignificant changes in behavior or happy and talking about her d how she enjoyed sewing, to set talking about the ad with her [family member] ident was transported to	F€	689			
	included, "On Wedr pm, I have got repo Caesar [sic] in her s -kill-myself," I-gave s if I can help her, par [family member, F-/ [F-A] and J [sic] ask [sic] and she gave t away from patient a [patient] talked to he showed such behave	dated 7/7/20, at 3:58 p.m. nesday July 1st at around 5:00 int that, the patient hid the shoe. Patient said "I want to cometime-to-patient-and-askedtient asked me if I can call her A], I promised her to call her ked her to give me the caesar o me. I put the Caesar [sic] and called her [F-A]. after pt er [F-A], pt was happy and not vior. Nurse told aid to watch any behavior repeated."				·	
	included, R1 had a 5:00 p.m., "Resident Assistant was doing with the she was going to kill notified a nurse and was going to kill her and R1 did hand the nurse placed the sc which was still acceleft facility in anticipation sweep was peobjects that resident	previous incident on 7/1/20, at thad two pairs of scissors. [RA] asked resident what she scissors and resident stated I herself with them." The RA I R1 repeated to the nurse she reelf. The nurse listened to R1 e scissors to the nurse. The issors in the resident's drawer ssible to R1."After resident ation of residents return, a erformed to identify any t could self-harm with and including the scissors." "The					

STATEMENT OF DEFICIENC AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	COM	E SURVEY IPLETED C	
		245637	B. WING			15/2020	
NAME OF PROVIDER OR S	SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 6993 80TH STREET SOUTH COTTAGE GROVE, MN 5501	16		
PREFIX (EACH D	EFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
written confile and re- Prevention policy. All of Threats to When inter licensed prevented a for self-har and noted When inter stated he very 7/2/20. N/6:00 a.m. struck him agitation to When inter stated wher found a par not aware with those was then be monitored the dresse was. When inter SSD had from and stayed hospital. Self-har	uty that rective a educate Policy a other sta Harm S received rectical rebout arm. She agitated received worked worked worked with help RN-H. I scissors eft alone RN-H is reviewed ound R1 with R2 SD had now to rem, but h	found the scissors received action to be placed in personnel d on Threats to Harm Self and and expectations to follow the aff to be re-educated on elf and Prevention Policy." on 7/13/20, at 1:30 p.m. nurse (LPN)-A stated she had by incident with R1 and had not at training on residents at risk had worked with R1 on 7/1/20 behaviors. on 7/13/20, at 1:45 p.m. NA-E with R1 on the morning of d R1 screaming and yelling at tempted to assist R1, but she cane. NA-E reported R1's on 7/13/20, at 1:55 p.m. RN-D d arrived at work on 7/2/20, he sors on R1's dresser, but was had threatened to harm herself and did not remove them. R1 in the room without being ater removed the scissors from N-D did not know what time this on 7/13/20, at 3:13 p.m. the with the butter knife on 7/2/20, I while awaiting transport to the not had any prior training at the espond to residents with threats ad notified nursing and stayed ed in the incident report. The		89			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245637	B. WING			1	C 15/2020	
	PROVIDER OR SUPPLIER SQUARE			69	FREET ADDRESS, CITY, STATE, ZIP CODE 993 80TH STREET SOUTH OTTAGE GROVE, MN 55016	1 011	10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 689	Harm Assessment ambulance. R1's Threats to Sel 7/2/20, included, "R from lunch to cut he writer this afternoor wanted to die and v conversation with h medication for anxiostated that she is so and is in a new env she has never done before. Writer stayed	ge 8 on 7/2/20, while waiting for the f Harm Assessment dated desident was using her knife er right wrist during visit with h. Resident stated she just was very upset after a phone er daughter. Resident is on ety and depression. She cared because she cannot see ironment She also told writer e anything like this to herself ed with resident until the to-transport-her-to-the-	F6	89				
	nursing assistant (N with R1 on 7/1/20, a light around 5:00 p.l hand and reported sher sleeve. NA-D a R1 refused to give the was going to kill her reported this immed scissors to RN-I. When interviewed of stated on 7/1/20, and her R1 had a pair of going to kill herself of R1's dresser in her a body assessment herself. RN-I left the returned R1 was on member. RN-I did in the signal of the scissors from the self. RN-I left the scissors R1 was on member. RN-I did in the signal of the scissors from the self. RN-I left the scissors R1 was on member. RN-I did in the signal of the scissors from the self. RN-I left the scissors R1 was on member. RN-I did in the signal of the scissors from the s	on 7/13/20, at 3:29 p.m. IA)-D stated he had worked and had answered her call m. R1 had a scissors in her she had another scissors up sked R1 for the scissors and them to him. R1 stated she reelf with the scissors. NA-D diately to RN-I. R1 gave the on 7/13/20, at 4:08 p.m. RN-I ound 5:00 p.m. NA-D notified f scissors and stated she was with them. RN-I was able to m R1 and placed them on top er room. RN-I stated she did to ensure R1 did not injure e room and when she the phone with a family not complete a essment of R1's suicide risk,						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '		INGCON		OMPLETED C	
		245637	B. WING			1	5/2020	
	PROVIDER OR SUPPLIER SQUARE		•	69	TREET ADDRESS, CITY, STATE, ZIP CODE 993 80TH STREET SOUTH OTTAGE GROVE, MN 55016			
(X4) 1D PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE.	(X5) COMPLETION DATE	
F 689	did not notify the pl did not report this is of nursing, or social place any intervent self, such as removed, (including the or place any other RN-I had not docur occurred on 7/1/20. When interviewed member (FM)-A state spoke on 7/1/20, a what they are trying don't know they are indicated they had scissors in her roof FM-A to tell them whospital. FM-A state a butter knife and tif the facility had cascissors and threat before, family woul and see what they prevent self-harm. never been relayed way to the hospital. When interviewed stated they had no training via Relias, about challenging with people with deno specific training ideation's in the part when interviewed stated they had no training via Relias, about challenging with people with deno specific training ideation's in the part when interviewed stated they had no when interviewed stated th	nysician or family member and necident to a manager, director all services. RN-I also did not ions to ensure R1 did not harmoving any sharp objects or e scissors) from R1's access interventions to protect R1. mented the incident that , until directed to on 7/7/20. on 7/13/20, at 4:24 p.m. family ated, R1 was upset when they ated, R1 was upset when they ated, R1 was upset when they ated, R1 was upset when they are trying to hurt me.' FM-A not been made aware R1 had m, and the facility only called when R1 was on the way to the ed the facility told them R1 had ried to kill herself. FM-A stated alled and told them R1 had tened to kill herself the day do have come to calm her down could do to get her help and However, this information had at to them until R1 was on the after the second incident. on 7/13/20, at 2:55 p.m. RN-A the worked with R1. RN-A had which is an online training, behaviors and communication amentia when hired. However, to self-harm or suicidal		689				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONST	(X3) DATE SURVEY COMPLETED			
		245637	B. WING		-		C 45(2020
	PROVIDER OR SUPPLIER	*** (max ****)		6993 80TI	DDRESS, CITY, STATE, ZIP CODE H STREET SOUTH SE GROVE, MN 55016	<u> </u>	15/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X6) COMPLETION DATE
F 689	ideation's. When interviewed of indicated she did nowith residents with stideation. When interviewed of stated the morning hitting the walls with hit staff also. RN-H doing that. She four dresser and remove from the cork board director-of-nursing-(sharp objects from them due to fear of and was not aware threatened to kill hem. On 7/14/20, at 11:44 reported she had not do if a resident threatened to kill hem. On 7/14/20, at 11:44 reported she would to do it, take the object and push the call lightere was not a syst precautions were constated she thought the rift there were presented she had just on how to manage streading some inform. When interviewed on DON stated, RN-H is sidents with the stated, RN-H is sidents.	on 7/13/20, at 3:34 p.m. NA-B of have training on working self-harm concerns or suicidal on 7/14/20, at 11:28 a.m. RN-H of 7/2/20, R1 was yelling and a her cane and attempted to stated she asked R1 to stop and scissors on top of R1's ed those and some pushpins. RN-H stated she let the DON)-know-she-had-removed-R1's room. She had removed R1 hurting staff with them, at that time that R1 had reself with those scissors. If a.m. housekeeper (H)-A of recently reviewed what to attend self harm. H-A probably tell the resident not ect away from the resident ht for a nurse. H-A reported from in which resident safety ommunicated to her. H-A he nursing assistant might tell	F 6	89			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i ' '		LE CONSTRUCTION		E SURVEY
		245637	B. WING	·			15/2020
	PROVIDER OR SUPPLIER		•	(STREET ADDRESS, CITY, STATE, ZIP CODE 6993 80TH STREET SOUTH COTTAGE GROVE, MN 55016		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	DON had not been with the scissors up the 7/2/20, incident DON stated for the have assessed R1 pairs of scissors, no practitioner, all while received disciplinate.	arp objects from her room. The aware of the 7/1/20 incident ntil after starting to investigate t with the butter knife. The 7/1/20, incident RN-I should for self harm, remove the two ot leave alone, and notify the ch were not done. RN-I had ry notice and training.	F	689			
	dietary aide (DA)-C day R1 was sent to aware of any concu utensils. This was DA-C had been aw plastic utensils rath and would have kn DA-C stated if a re objects such as kn noted on their dieta received any training	on 7/14/20, at 11:45 a.m. C stated they had worked the othe hospital. DA-C was not ern about R1 having any sharp not relayed to dietary staff. If ware, they would have provided her than a regular butter knife flown to cut up food for R1. I sident should not have sharp lives or glassware, it should be any card. DA-C had nevering from the facility on what to eatened suicide or self-harm.					
	DA-B stated that la sheet to read on si was at risk of harm received any traini read the sheet. Do how dietary would wanted to harm the but didn't know wh When interviewed DA-A indicated she working with reside	on 7/14/20, at 11:20 a.m. ast week they were given a igns to watch for if someone ning themselves, but had not ng. They had to sign that they A-B stated she doesn't know be informed if someone emselves and wanted to ask, to to ask follow up questions to. on 7/14/20, at 11:22 a.m. to did not have training on ents with self-harm concerns or but last week they had to read					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245637	B. WING_		07	C / 15/2020
NAME OF PROVIDER OR SUPPLIER NORRIS SQUARE				STREET ADDRESS, CITY, STATE, ZIP CO 6993 80TH STREET SOUTH COTTAGE GROVE, MN 55016		113/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	indicated supervisoral resident has any self-harm or special also stated she diduknow about suicidal because that was a Portability and Accommodated dietary staroom because R1 has been because R1 has been because R1 has been because R1 has been because R1 has been because R1 has been because R1 has been because R1 has been because R1 has been because R1 has been because R1 has been been because R1 has been been been been been been been bee	ry staff should let them know if precautions related to I dinging service needs. DA-An't think dietary staff could I tendencies in a resident I, "HIPPA [Health Insurance puntability Act] thing." DA-A aff were told not to enter R1's nad hit an aide with her cane. ot given any instruction to as knives or sharp objects	F 68	89		
	director-of-dietary-sishould be dining procession of the dining procession of the dincluding only giving glass or something also indicated that the dincluding only giving also indicated that the dining of the din	ak down. DĎS stated if we e, they would have only				
	RN-G stated that wherself on 7/1/20, R procedure which was coordinator and directly 911, and not leave to should have remove use to harm themse resident was safe. The state of the state o	on 7/14/20, at 11:50 a.m. hen R1 was threatening to kill N-I should have followed their as to notify the clinical ector of nursing (DON), call he resident alone. Staff ed all objects residents could elves and make sure the Dietary should have notified bjects that could be used to				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDING				COMPLETED	
		245637	B, WING		1919.	1	5/2020	
NAME OF PROVIDER OR SUPPLIER NORRIS SQUARE				6	STREET ADDRESS, CITY, STATE, ZIP CODE 1993 80TH STREET SOUTH COTTAGE GROVE, MN 55016			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X6) COMPLETION DATE	
F 689	interventions shoul stated since the far suicidal ideation's they had not done staff. However, the training on vulnerar observing and report when interviewed NA-C indicated she training on working concerns or suicidan annual Relias the education here. I way supervisor or a nure determine what to person was going that I was there, walone, would look to clip or any kind of harm themselves, When interviewed RN-C indicated she working with reside suicidal ideation in A facility education Handling Suicide Tharm Self and Preto sign indicating sthis. Staff who had incident with R1, bp.m. yet to receive RN-B, RN-C, RN-E, NA-D, NA-F, PT-A the administrator.	narm and immediate d have been placed. RN-G cility is so new and self-harm or had never come up before, any specific training on this for ere was a Relias annual ble adult requirements,	F	689				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245637	B. WING			07	C //15/2020
NAME OF PROVIDER OR SUPPLIER NORRIS SQUARE				6993 80TI	DDRESS, CITY, STATE, ZIP CODE H STREET SOUTH SE GROVE, MN 55016		
(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 ROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 689	Threats Policy, revi 1. All suicide threa evaluated based or observed/assessed and what the physic 2. If a resident/clie designate a staff per while the nurse is n 3. The nurse will redesignee to assist in psychologist or psyc 4. The nurse will repromptly a recomm will be reviewed with consideration-of-eith services or in-house 5. Remove as mainstruments from the medications, razors neckties, and panty 6. Obtain direction psychiatric consultate medication alteration amount of time to readmission to an inp strongly considered 7. If satisfying direct for the physician an unmanageable suic you feel that the res renders him/her dar 8. Take time to tall questions to ask a president/client. 9. Assure that suff assessment is sche	ewed 2/16, indicated: ats will be taken seriously and a what is known and regarding the resident/client clan recommends. ent threatens suicide, erson to stay with him or her otified. notify the social worker or assessment and include a chiatrist as available. notify the family and physician endation for psych services the physician and family for ner-inpatient-geri-psych ereferral. ny potentially lethal e room as possible, including ton, tableware, nail files, glass, hose. from physician regarding tion, transfer to hospital, at if suicidal threats are made, as may take an extended each full effectiveness. Intified plan threat is known atient setting should be totion has not been received d/or if any subsequent ide threats are made, and/or if ident/client's mental condition agerous to self, call 911. k to the resident/client. See	F 6	39			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				COMPLETED	
		245637	B. WING	;			5/2020
	PROVIDER OR SUPPLIER SQUARE			6	TREET ADDRESS, CITY, STATE, ZIP CODE 1993 80TH STREET SOUTH COTTAGE GROVE, MN 55016		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	of monitoring. 10. If after repetitive need for 1:1 supers the facility cannot pand safety of the reinterdisciplinary teaphysician and psychalternate placemer 11. In the event the need continuous of plan is implemente summoned, 1:1 su supervision through used as indicated a consents and HIPF. The immediate jeowas removed on 7 reviewed their policiall staff would be tresidents who may themselves, prior to However, the noncolower scope and second the residents who may the scope and second the residents who may the scope and second the residents who may the scope and second the residents who may the scope and second the residents who may the scope and second the residents who may the scope and second the residents who may the scope and second the residents who may the scope and second the residents who may the scope and second the residents who may the scope and second the residents who may the scope and second the residents who may the scope and second the residents who may the scope and second the scope and second the residents who may the scope and second the scope and scope and scope and scope and scope and scope and scope and scope and scope	de risk to determine frequency be suicidal ideation's or the vision, it becomes evident that provide adequate supervision esident or others, the arm in partnership with the has ervices should consider at. The resident is determined to be servation until a longer term of or emergency personnel are pervision or indirect and compliant with appropriate PA requirements. The part of the test of the facility be and compliant with appropriate PA requirements. The part of the facility be at risk of harming the beat risk of harming to be at risk of harming the peverity level of a D- isolated to the provision of the potential for		689			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered July 31, 2020

Administrator Norris Square 6993 80th Street South Cottage Grove, MN 55016

Re: State Nursing Home Licensing Orders

Event ID: PZRP11

Dear Administrator:

The above facility was surveyed on July 13, 2020 through July 15, 2020 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:

Karen Aldinger, Unit Supervisor Metro A Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: karen.aldinger@state.mn.us

Phone: (651) 201-3794 Mobile: (320) 249-2805

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,

Kamala Fiske-Downing

Minnesota Department of Health

Kumalu Fiske Downing

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C 33301 07/15/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6993 80TH STREET SOUTH NORRIS SQUARE **COTTAGE GROVE, MN 55016** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section Corrected. 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 7/13/20, through 7/15/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to NOT be in compliance with the MN State Licensure. The following complaint found to be Minnesota Department of Health

, Waller

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Care Cover Alministration

8/7/2020

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING: C B. WING 07/15/2020 33301 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6993 80TH STREET SOUTH **NORRIS SQUARE COTTAGE GROVE, MN 55016** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 000 2 000 Continued From page 1 SUBSTANTIATED: H5637005C, licensing orders were issued. The following complaint was found to be SUBSTANTIATED: H5637007C, no licensing orders were issued. The following complaint was found to be UNSUBSTANTIATED: H5637006C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. 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 surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm The State licensing orders are delineated on the attached Minnesota

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PRINTED: 07/31/2020 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ C B. WING 33301 07/15/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6993 80TH STREET SOUTH NORRIS SQUARE **COTTAGE GROVE, MN 55016** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 2 000 Continued From page 2 2 000 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES. "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS-WILL-APPEAR-ON-EACH-PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. MN Rule 4658.0520 Subp. 1 Adequate and 2 830 Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a

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written order from the attending physician that the resident must remain in bed or the resident

This MN Requirement is not met as evidenced

prefers to remain in bed.

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of resident trying to harm self. After resident admitted to this facility she did not voice any

FORM APPROVED Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _____ C 07/15/2020 33301 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6993 80TH STREET SOUTH **NORRIS SQUARE COTTAGE GROVE, MN 55016** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (FACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 2 830 2 830 Continued From page 5 concerns with self harm and there were no indications that resident would self harm. Internal investigation started and all parties notified." R1's progress note dated 7/2/20, at 1:07 a.m. indicated R1 was agitated and restless early in the shift and wanted to go to the bathroom right away. The progress note further indicated R1 pretended to take her medications, but would hide medication in her pocket and was educated about the risk of not taking medications. However, the note failed to include any attempt to find out why R1 did not want to take the medication or source of her agitation. R1's progress note dated 7/2/20, at 8:09 a.m. included, "Yelling out taking off her oxygen. Writer approached resident to see how she could be helped. Resident had her phone, her call light her oxygen and her radio all in her left hand with lines twisted. Resident had walking cane in right hand. As writer approached resident swung cane in direction of writer. Writer grabbed cane to stop cane from hitting writer. Resident stated that she didn't mean to hit writer and began to calm down. Writer untangled all the cords and organized room, placed 02 [oxygen] back on resident. Offered PRN [as needed] lorazapem for anxiety but resident refused. Attempted to give AM medications but resident stated that it was too early for that. Was then making statements like. 'Why are you guys so nice to me?' but then would say 'I know you're going to kill me.' Then asked writer to call family member [F-A]. Writer called [F-A] and left resident alone, letting her know that writer would be back after breakfast for her

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morning medications." The note failed to include

R1's progress note dated 7/2/20, at 10:34 a.m.

an assessment of R1's distress.

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Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _____ C 07/15/2020 33301 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6993 80TH STREET SOUTH **NORRIS SQUARE COTTAGE GROVE, MN 55016** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 830 2 830 Continued From page 7 her [family member] earlier this afternoon. She said, 'I shouldn't have done that. Now I don't have a phone,' and was very tearful. Writer reassured resident that staff can get her a new phone. Resident also told writer that she is scared because she can't see, and she has anxiety. Resident stated she does not have a plan in place to kill herself, and that this is the first time she has done something like this. She asked writer not to say anything to anyone about her wrist. Writer explained that she has to tell the nursing staff so they can help her and that she will be going to the hospital, as 911 was already called. Writer sat with resident talking with her until ambulance arrived to take her to the hospital. She had significant changes in behavior during that time, from happy and talking about her [family member] and how she enjoyed sewing, to very tearful and upset talking about the conversation she had with her [family member] this afternoon. Resident was transported to United Hospital per [family member's] recommendation." R1's progress note, dated 7/7/20, at 3:58 p.m. included, "On Wednesday July 1st at around 5:00 pm, I have got report that, the patient hid the Caesar [sic] in her shoe. Patient said "I want to kill myself." I gave sometime to patient and asked if I can help her, patient asked me if I can call her [family member, F-A], I promised her to call her [F-A] and J [sic] asked her to give me the caesar [sic] and she gave to me. I put the Caesar [sic] away from patient and called her [F-A]. after pt [patient] talked to her [F-A], pt was happy and not showed such behavior. Nurse told aid to watch the pt and report if any behavior repeated." R1's Investigation Summary, dated 7/8/20, included, R1 had a previous incident on 7/1/20, at

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was then left alone in the room without being

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When interviewed on 7/13/20, at 2:55 p.m. RN-A

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her if there were precautions.

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C 33301 07/15/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6993 80TH STREET SOUTH **NORRIS SQUARE COTTAGE GROVE, MN 55016** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 830 Continued From page 12 2 830 When interviewed on 7/14/20, at 12:11 p.m. NA-F stated she had just received some training today on how to manage self-harm behaviors, by reading some information and signing a form. When interviewed on 7/14/20, at 1:27 a.m. the DON stated. RN-H had reported on 7/2/20 that R1 was striking out at staff with her cane and had removed some sharp objects from her room. The DON had not been aware of the 7/1/20 incident with the scissors until after starting to investigate the 7/2/20, incident with the butter knife. The DON stated for the 7/1/20, incident RN-I should have assessed R1 for self harm, remove the two pairs of scissors, not leave alone, and notify the practitioner, all which were not done. RN-I had received disciplinary notice and training. When interviewed on 7/14/20, at 11:45 a.m. dietary aide (DA)-C stated they had worked the day R1 was sent to the hospital. DA-C was not aware of any concern about R1 having any sharp utensils. This was not relaved to dietary staff. If DA-C had been aware, they would have provided plastic utensils rather than a regular butter knife and would have known to cut up food for R1. DA-C stated if a resident should not have sharp objects such as knives or glassware, it should be noted on their dietary card. DA-C had never received any training from the facility on what to do if someone threatened suicide or self-harm. When interviewed on 7/14/20, at 11:20 a.m. DA-B stated that last week they were given a sheet to read on signs to watch for if someone was at risk of harming themselves, but had not received any training. They had to sign that they read the sheet. DA-B stated she doesn't know how dietary would be informed if someone

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FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED. AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C B. WING 07/15/2020 33301 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6993 80TH STREET SOUTH **NORRIS SQUARE COTTAGE GROVE, MN 55016** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 830 2 830 Continued From page 13 wanted to harm themselves and wanted to ask, but didn't know who to ask follow up questions to. When interviewed on 7/14/20, at 11:22 a.m. DA-A indicated she did not have training on working with residents with self-harm concerns or suicidal ideation, but last week they had to read and sign sheet on what signs to watch for. DA-A indicated supervisory staff should let them know if a resident has any precautions related to self-harm or special dinging service needs. DA-A also stated she didn't think dietary staff could know about suicidal tendencies in a resident because that was a, "HIPPA [Health Insurance Portability and Accountability Act thing." DA-A indicated dietary staff were told not to enter R1's room because R1 had hit an aide with her cane. Dietary staff were not given any instruction to withhold items such as knives or sharp objects from R1's meal tray. When interviewed on 7/14/20, at 11:45 a.m. the director of dietary services (DDS) indicated there should be dining precautions in place for residents identified with risk for self-harm including only giving them plastics, and not giving glass or something that would break. The DDS also indicated that they would also give a lighter weight plastic silverware, and a plastic knife only if needed. The DDS indicated they did not know what happened in R1's case, and they would have to check with staff to verify the communication break down. DDS stated if we had known the issue, they would have only provided disposable plastic.

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When interviewed on 7/14/20, at 11:50 a.m. RN-G stated that when R1 was threatening to kill herself on 7/1/20, RN-I should have followed their

procedure which was to notify the clinical

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Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ C B. WING 33301 07/15/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6993 80TH STREET SOUTH **NORRIS SQUARE COTTAGE GROVE, MN 55016** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 2 830 Continued From page 14 2 830 coordinator and director of nursing (DON), call 911, and not leave the resident alone. Staff should have removed all objects residents could use to harm themselves and make sure the resident was safe. Dietary should have notified not to provide any objects that could be used to harm oneself if at risk. R1 should have been assessed for self-harm and immediate interventions should have been placed. RN-G stated since the facility is so new and self-harm or suicidal ideation's had never come up before, they had not done any specific training on this for staff. However, there was a Relias annual training on vulnerable adult requirements, observing and reporting. When interviewed on 7/14/20, at 12:28 p.m. NA-C indicated she did not receive on-site training on working with residents with self-harm concerns or suicidal ideation and stated, "We do an annual Relias training but I did not receive any education here. I would definitely try to find a supervisor or a nurse, talk to the resident to determine what to do best, especially if felt the person was going to actively do it in the minutes that I was there, would not leave the person alone, would look for sharp objects, remove call clip or any kind of cord or anything they could harm themselves, get it totally out of the room." When interviewed on 7/14/20, at 12:35 p.m. RN-C indicated she did not receive training on working with residents with self-harm concerns or sujcidal ideation in the last couple weeks. A facility education entitled Guidelines for Handling Suicide Threats Policy and Threats to

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Harm Self and Prevention Policy had a document to sign indicating staff had received training on this. Staff who had worked since the 7/2/20,

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Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _____ C 07/15/2020 33301 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6993 80TH STREET SOUTH NORRIS SQUARE **COTTAGE GROVE, MN 55016** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 830 2 830 Continued From page 15 incident with R1, but had as of 7/14/20, at 12:49 p.m. yet to receive the training included: RN-A, RN-B, RN-C, RN-E, RN-F, NA-A, NA-B, NA-C, NA-D. NA-F. PT-A. DA-C. This was verified by the administrator. The facilities Guidelines for Handling Suicide Threats Policy, reviewed 2/16, indicated: 1. All suicide threats will be taken seriously and evaluated based on what is known and observed/assessed regarding the resident/client and what the physician recommends. 2. If a resident/client threatens suicide, designate a staff person to stay with him or her while the nurse is notified. 3. The nurse will notify the social worker or designee to assist in assessment and include a psychologist or psychiatrist as available. 4. The nurse will notify the family and physician promptly a recommendation for psych services will be reviewed with the physician and family for consideration of either inpatient geri-psych services or in-house referral. 5. Remove as many potentially lethal instruments from the room as possible, including medications, razors, tableware, nail files, glass, neckties, and panty hose. 6. Obtain direction from physician regarding psychiatric consultation, transfer to hospital, medication. Note that if suicidal threats are made. medication alterations may take an extended amount of time to reach full effectiveness. Therefore, if an identified plan threat is known admission to an inpatient setting should be strongly considered. 7. If satisfying direction has not been received for the physician and/or if any subsequent unmanageable suicide threats are made, and/or if

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you feel that the resident/client's mental condition renders him/her dangerous to self, call 911.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
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2 830	8. Take time to tal questions to ask a president/client. 9. Assure that suff assessment is schereduce the chance for assessing suicid of monitoring. 10. If after repetitive need for 1:1 supervithe facility cannot preside the chance of the resinterdisciplinary teal physician and psych	k to the resident/client. See potentially suicidal ficient observation and eduled around the clock to of self injury. See guidelines le risk to determine frequency e suicidal ideation's or the ision, it becomes evident that rovide adequate supervision sident or others, the m in partnership with the in services should consider	2 830					
	need continuous ob plan is implemented summoned, 1:1 sup supervision through	t the resident is determined to servation until a longer term d or emergency personnel are servision or indirect video observation may be nd compliant with appropriate						
	was removed on 7/reviewed their polici all staff would be tra- residents who may themselves, prior to However, the nonco- lower scope and se	pardy that began on 7/1/20, 15/20, when the facility les/procedures and ensured alined in how to manage be at risk of harming beginning their next shift. It is ampliance remained at the verity level of a D- isolated ual harm with potential for narm.						
	Nursing or designed procedures, train state to assure resident's are protected. The	of Correction: The Director of could review policies and aff, and implement measures who are at risk of self-harm director of nursing or duct random audits of the						

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _____ C 07/15/2020 33301 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6993 80TH STREET SOUTH **NORRIS SQUARE COTTAGE GROVE, MN 55016** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 830 2 830 Continued From page 17 delivery of care; to ensure appropriate care and services are implemented; to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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