Electronically delivered
May 26, 2022

Administrator
Regina Senior Living
1175 Nininger Road
Hastings, MN 55033

RE: CCN: 245254
Cycle Start Date: May 17, 2022

Dear Administrator:

On May 17, 2022, a survey was completed at your facility by the Minnesota Department of Health 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 immediate jeopardy (Level J).

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On May 6, 2022, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty, (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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, Regina Senior Living is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effectiveNO DATA. 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.

DEPARTMENT CONTACT

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

Supervisor signature block goes here

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those

preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

(signature block here)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	C 05/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 5/17/22, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The following complaint H52541682C (MN83273) was SUBSTANTIATED at F689 for PAST NON-COMPLIANCE. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F689 began on 5/5/22, when facility staff utilized a small mechanical lift sling instead of a medium, per R1's care plan, and R1 fell from the mechanical lift and hit their head. The administrator, and director of nursing (DON) were notified of the IJ on 5/17/22, at 3:35 p.m. The facility implemented corrective action on 5/6/22, and the IJ was issued as past non-compliance. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the correction. NO plan of correction is required for a finding of past non-compliance. The facility is still required to acknowledge receipt of the electronic documents.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		

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

Electronically Signed | 05/27/2022

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 689	Continued From page 1 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to use the appropriate sized mechanical lift sling for 1 of 3 residents (R1) reviewed for falls. This resulted in an immediate jeopardy (IJ) for R1 who fell during a mechanical lift transfer and hit their head. The IJ began on 5/5/22, at 9:00 a.m. when facility staff utilized improper sized mechanical lift sling. R1 fell, after being suspended in the air, and hit their head. The administrator and assistant director of nursing (ADON) were notified of the IJ on 5/17/22, at 3:35 p.m. The facility implemented corrective action on 5/6/22, and the IJ was issued as past non-compliance. Findings include: R1's quarterly Minimum Data Set (MDS) dated 3/15/22, indicated R1 was severely cognitively impaired with a diagnosis of hemiplegia and hemiparesis affecting the right side. R1 required extensive assistance with two staff for transfers. R1's care plan dated 7/16/21, identified, R1 had a deficit with activities of daily living (ADLs) including transferring and mobility. The care plan directed two staff, with the use of a Hoyer lift (mechanical full-body lift) and a medium sling, were required to transfer R1. A incident report dated 5/5/22, at 11:36 a.m. included, "R1 fell out of hoyer sling." "R1 fell four feet out of hoyer sling." "R1 was in a size small sling." "R1 is supposed to be using a medium	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2 sling." R1's progress note dated 5/5/22, at 10:03 a.m. included, two nursing assistants were transferring R1 from the wheelchair back to bed using a Hoyer lift. R1 fell out of the sling and onto the floor. When interviewed on 5/17/22, at 11:20 a.m. nursing assistant (NA)-A stated, me and NA-B were transferring R1 back to bed after breakfast using a small Hoyer sling. R1 complained of neck pain, attempted to readjust positions, and fell from the Hoyer sling onto the floor. NA-A stated the small sling was used because it was the one always in R1's room. NA-A verified the care plan was not reviewed for the proper sling size prior to using the Hoyer lift to transfer R1. When interviewed on 5/17/22, at 11:56 a.m. NA-B stated, me and NA-A were transferring R1 back to bed after breakfast from the wheelchair using the small Hoyer sling. R1 complained of shoulder pain and started "wiggling" to readjust positions and fell out of the side of the Hoyer sling onto the floor. Further, NA-B stated the sling size was not checked due to being in a hurry. NA-B verified the sling tag with the size was not checked and compared with the care plan prior to using the Hoyer lift to transfer R1. When interviewed on 5/17/22, at 12:23 p.m. the executive director verified NA-A and NA-B did not follow the plan of care when transferring R1 with the Hoyer lift. Further, verified R1 had the potential for a serious injury from the fall. When interviewed on 5/17/22, at 1:32 p.m. the nurse practitioner (NP)-A verified R1 had the	F 689		

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F 689	Continued From page 3 potential to sustain a serious injury including death due to the fall from the Hoyer. When interviewed on 5/17/22, at 2:35 p.m. the assistant director of nursing (ADON) verified not following the care plan played a role in R1 falling from the Hoyer lift onto the floor. Further, the NA's were trained on how to confirm the sling size and how to access the care plan to review the proper sling size to use during transfers. The facility integrated fall management policy undated, included, the facility was to identify and implement appropriate interventions as necessary, to maintain resident safety, prevent falls and reduce further injury from falls. Further, interventions are implemented through the resident centered care plan. The past non-compliance IJ which began on 5/5/22, was removed on 5/6/22, after the facility implemented a systemic plan that included the following: - On 5/5/22, immediately after the incident occurred, maintenance inspected the Hoyer lift and the sling to ensure the items were working properly. This was verified by a lift inspection report. - On 5/5/22, the clinical manager completed an audit of each resident, who utilized a Hoyer lift, to ensure the appropriate sling size was care planned, listed on the group sheet, and the proper sling size was available. This was verified by a written statement dated 5/5/22. - On 5/5/22, both NA-A and NA-B completed a mechanical lift audit to ensure proper use of a Hoyer lift. This was verified by mechanical lift audit forms dated 5/5/22. - On 5/5/22, the nursing staff were educated	F 689		

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F 689	Continued From page 4 immediately on the shift the fall occurred. Other nursing staff were educated prior to working their next shift on ensuring appropriate sling size was utilized during transfers and re-trained to refer to the group sheets and care plan. This was verified by sign in sheet dated 5/5/22. - Starting on 5/5/22, nursing completed weekly mechanical lift audits with the nursing staff. This was verified by signed and dated audit forms. - NA-A, NA-B, NA-C, and LPN-A were interviewed on 5/17/22, and verified they had received education on ensuring the appropriate sling size was utilized during transfers and referring to the group sheets and care plans.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 26, 2022

Administrator
Regina Senior Living
1175 Nininger Road
Hastings, MN 55033

Re: Event ID: G2WQ11

Dear Administrator:

The above facility survey was completed on May 17, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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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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 5/17/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H52541682C (MN83273), however, NO licensing orders were issued. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		