DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: HJY5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00374

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245127**

2.STATE VENDOR OR MEDICAID NO.
(L2) **190247401**

3. NAME AND ADDRESS OF FACILITY
(L3) **MILLE LACS HEALTH SYSTEM**
(L4) **200 NORTH ELM STREET**
(L5) **ONAMIA, MN** (L6) **56359**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/23/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **57** (L18)

13.Total Certified Beds **57** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	57			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Austin Fry, HFE NE II — 09/23/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 10/14/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
03/20/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 10/27/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/16/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245127
October 14, 2015

Ms. Kim Kucera, Administrator
Mille Lacs Health System
200 North Elm Street
Onamia, Minnesota 56359

Dear Ms. Kucera:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective August 21, 2015 the above facility is certified for or recommended for:

57 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 57 skilled nursing facility beds located in rooms .

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 14, 2015

Ms. Kim Kucera, Administrator
Mille Lacs Health System
200 North Elm Street
Onamia, Minnesota 56359

RE: Project Number S5127025

Dear Ms. Kucera:

On August 10, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an extended survey, completed on July 27, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 23, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on July 27, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 21, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 27, 2015, effective August 21, 2015 and therefore remedies outlined in our letter to you dated August 10, 2015, will not be imposed.

However, as we notified you in our letter of August 10, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 27, 2015.

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.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245127	A. Building B. Wing	9/23/2015

Name of Facility	Street Address, City, State, Zip Code
MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program , to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **08/13/2015**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **08/21/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **08/21/2015**
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **08/14/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **08/20/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **08/20/2015**
ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **08/20/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **08/18/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	10/14/2015	33925	09/23/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/27/2015			

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 14, 2015

Ms. Kim Kucera, Administrator
Mille Lacs Health System
200 North Elm Street
Onamia, Minnesota 56359

Re: Reinspection Results - Project Number S5127025

Dear Ms. Kucera:

On September 23, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 27, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00374	A. Building B. Wing	9/23/2015

Name of Facility	Street Address, City, State, Zip Code
MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **20302** Reg. # **MN State Statute 144.6503** LSC	**09/23/2015**	ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	**08/20/2015**	ID Prefix **20905** Reg. # **MN Rule 4658.0525 Subp. 4** LSC	**08/20/2015**
ID Prefix **20910** Reg. # **MN Rule 4658.0525 Subp. 5 A.I** LSC	**08/20/2015**	ID Prefix **21565** Reg. # **MN Rule 4658.1325 Subp. 4** LSC	**08/13/2015**	ID Prefix **21685** Reg. # **MN Rule 4658.1415 Subp. 2** LSC	**08/20/2015**
ID Prefix **21805** Reg. # **MN St. Statute 144.651 Subd. 5** LSC	**08/13/2015**	ID Prefix **21990** Reg. # **MN St. Statute 626.557 Subd. 4** LSC	**08/21/2015**	ID Prefix **22000** Reg. # **MN St. Statute 626.557 Subd.** LSC	**08/21/2015**
ID Prefix Reg. # LSC	Completed	ID Prefix Reg. # LSC	Completed	ID Prefix Reg. # LSC	Completed
ID Prefix Reg. # LSC	Completed	ID Prefix Reg. # LSC	Completed	ID Prefix Reg. # LSC	Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	BF/KJ	10/14/2015	33925	09/23/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/27/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: HJY5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00374

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245127**

2.STATE VENDOR OR MEDICAID NO.
(L2) **190247401**

3. NAME AND ADDRESS OF FACILITY
(L3) **MILLE LACS HEALTH SYSTEM**
(L4) **200 NORTH ELM STREET**
(L5) **ONAMIA, MN** (L6) **56359**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/27/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **57** (L18)

13.Total Certified Beds **57** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	57			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Bruce Melchert, HFE NE II 08/27/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 09/14/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
03/20/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 4, 2015

Ms. Kim Kucera, Administrator
Mille Lacs Health System
200 North Elm Street
Onamia, Minnesota 56359

****This letter redacts and replaces the letter dated August 10, 2015.****

RE: Project Number S5127025

Dear Ms. Kucera:

On July 27, 2015, an extended survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Substandard Quality of Care - means one or more deficiencies related to participation

requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

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:

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
Health Regulation Division
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 5, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 5, 2015 the following remedy will be

imposed:

- Per instance civil money penalty (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Mille Lacs Health System is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective July 27, 2015. 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.

APPEAL RIGHTS

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

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:

Jan.Suzuki@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 Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above.

If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by October 27, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 27, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245127	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An extended survey was conducted by the Minnesota Department of Health on 7/27/2015	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure safe self-administration of medications (SAM) for 1 of 1 residents (R63) observed for self-administration of a nebulizer treatment. Findings include: During observation on 7/20/15, at 7:28 p.m. R63 was observed alone in her room with a nebulizer (a drug delivery device used to administer medications in the form of a mist inhaled into the	F 176	R-63 with the Potential to Affect all residents who have orders to receive nebulizer treatments. 1. On 7/28/15 TMA-A was coached on Self administered nebulizers vs not self administered nebulizers. She was also given the policy on Self-administered medication. 2. On 8/12/15 The MAR of all residents who have an order for Nebulizer treatment were updated to indicate if they have met the	8/13/15

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

Electronically Signed | 08/21/2015

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F 176	Continued From page 1 lungs) running, with a face mask. The trained medication aide (TMA)-A who had administered the medication was on the opposite side of the dining room passing medications and assisting other residents in their rooms. R63 removed the mask off her nose and mouth and placed the mask on her chest with the elastic strap still around the back of her neck. TMA-A walked past R63's room while R63 had the mask on her chest and into the room next to R63 twice. TMA-A made no attempted to check, or reapply the mask to R63's nose and mouth for installation of the medication. At 7:44 p.m. TMA-A entered R63's room, turned off the nebulizer and removed the mask from R63's chest. R63's diagnoses included dementia with behavioral disturbances, depression, anxiety, chronic obstructive pulmonary disease (COPD) and congestive heart failure. A cognition care plan dated 6/2/15, indicated R63 was disorientated to time and place and had moderately impaired cognition. The Physician's Orders and the Medication Administration Record (MAR) for 7/15, directed Duoneb to be administered four times a day. A hand written note on the MAR indicated R63 did not like the nebulizer mask and to hold the mask in front of her face and let her breathe in that way. A Self Administration of Medication Assessment effective 7/21/15, indicated R63 was not cognitively able to participate in a SAM. During interview on 7/20/15, at 7:50 p.m. TMA-A stated she did not know if R63 could be left alone with the nebulizer. TMA-A added she usually does not leave residents alone with their	F 176	requirements allowing to self administer their Nebulizer treatment. 3. On 8/13/13 An email was sent to all nurses regarding the administration of self-administered medication. Any Resident that is allowed to self administer their nebulizers will be noted in the MAR, If this is not noted the nurse must REMAIN with the resident during the treatment. A memo was placed on each Medication Cart. Monitoring 1. Starting 8/24/15-9/28/15 An audit will be completed on a minimum of 5 residents who have scheduled Neb. treatments every day x1 week, then every week x 4 weeks to ensure all residents who do not have an order to self administer medication are being observed during the treatment (Attachment A) Responsibility Parties: Care Coordinators or DON Audit reports will be reported to the Quality Assurance Committee. (QA meets quarterly; Oct., Jan., April and July).	

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F 176	Continued From page 2 nebulizer but because it had been so hectic and busy she left R63 alone. On 7/23/15, at 11:20 a.m. registered nurse (RN)-A stated R63 was assessed to not to be left alone to SAM the nebulizer. In the past she would not even allow the mask but now will allow staff to hold the mask in front of her.	F 176		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225		8/21/15

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F 225	Continued From page 3 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure all allegations of abuse, neglect, mistreatment and injuries of unknown were immediately reported to the adminstrator and state agency, were thoroughly investigated, and residents were protected during their investigations for 8 of 15 residents' (R47, R12, R22, R39, R11, R66, R44 and R8) allegations reviewed. The facility failed to conduct reference checks for 4 of 5 newly hired employees (NA-A, NA-B, DA-A and RN-B). Findings include: Investigation and Protection During interview 7/23/15, at 5:09 p.m. with social worker (SW) stated that nursing assistant (NA)-C has been implicated in four incident reports from January 2015 to July 2015 as the potential alleged perpetrator (AP). Review of facility Incident and Investigation reports indicated the following: R47's quarterly Minimum Data Set (MDS) dated 2/17/15, indicated she was moderately cognitively	F 225	Investigation and Protection: Affects residents R47, R12, R22, R39, R11, R66, R44, R8 with the Potential to affect All Residents. Injuries of Unknown Origin: Affects residents R39, R11, R66, R44, R8 with the Potential to affect All Residents. Corrections support investigation, protection and injuries of unknown origin 7/24/15 @ 10:35 PM: A Performance Improvement Plan was delivered and implemented effective immediately with NA-C. (Attachment B). One said measurement included NO complaints regarding care action during the shift. Failure to meet this goal will result in further disciplinary action up to termination. 7/29/15 In order to ensure the protection and safety of R22 it was decided that at this time 2 staff would be required in the room when providing care. This was discussed at R22's Care Conference and was approved by both R22 and her family.	

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F 225	Continued From page 4 intact and needed extensive assistance in ADLs. R47's care plan dated 2/26/15, indicated she had dementia and needs assist with dressing, grooming and bathing. The care plan further indicated she had slight alteration in cognition related to dementia and that resident will continue to be oriented to person, place and time. Mille Lacs Nursing Home Progress Notes dated 1/24/15, at 3:49 a.m. indicated: "This nurse [LPN-D] was in a res. room, 5 rooms away from where the incident happened, but heard a distinct smack. Followed by a woman's out cry. This nurse then got a call on the walkie [walkie-talkie] from the aide. The aide stated (in her words) On 2 a.m. rounds, I went to check resident in room 45-1 and woke up resident in 45 -2 [R47] in the process. I told [R47] the time and said she should lay back down and try and get some sleep until coffee time. [R47] said "No, I want to sit up I'm waiting." NA-C said "No lets lay down" and NA-C went to pick up [R47's] feet to bring them in bed and [R47] swung and hit me in the head, fairly hard. I [NA-C] yelled out "ow" and NA-C said "why did you hit me, R47 said "I didn't, you hit me you liar" then [NA-C] walked out and walkie the nurse...." This nurse [LPN-D] asked the res. why she hit the aide. Res. [R47] stated that the aide hit her." An Incident Report submitted to the state agency on 1/28/15, indicated that R47 had a conflict with a nursing assistant on 1/24/15. Following a review of the related progress notes, and supervisory staff, it was originally determined R47's incident was due to her dementia. Further study revealed that R47 allegedly struck a nursing assistant, but resident [R47] also alleged the nursing assistant struck her. The report indicated	F 225	8/15/15 Existing VA tracking log revised to include identity of alleged perpetrators to better identify trends occurring, including those incidents that have been ¿unable to substantiate.¿ The Log will be updated at the time investigation results are submitted to OHFC and again when the investigation is closed. Upon Closure of each incident the VA Log will be electronically forwarded by LSW to administrator to assure the administrator is kept informed of the FULL STATUS of the investigations with regards to timeliness of report submissions, final disposition and actions taken with regards to alleged perpetrator. Person(s) responsible: LSW On 8/17/15: Facility wide Vulnerable Adult Policy (Attachment C) revised to delineate protections for residents This includes CMS language defining injuries of unknown source. On 8/18/15: Administrator and Medical Director sent a letter (Attachment D) to all residents and/or their representatives regarding survey findings; how, what and how often we educate staff and the facility¿s commitment to protecting vulnerable adults. A flier with information on warning signs of abuse and neglect, and a copy of the staff education over the last 12 months were included with the letter. On 8/19/15 Social Service Incident Reporting Form (Attachment E) was	

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F 225	Continued From page 5	F 225		

a further investigation needed to be completed.

A follow-up Investigative Report was submitted to the state agency on 2/2/15. The report indicated the SW met with the resident R47 on the a.m. of 1/28/15 and 1/30/15 and resident was unable to recall any incidents of concerns. The SW was unable to speak with NA-C until 2/2/15 (7 days after the SW learned of the situation) in part due to her work schedule not coinciding with the SW. SW spoke with NA-C by phone on 2/2/15, at 10:45 p.m. NA-C acknowledged the incident happened as described by LPN-D's note. NA-C stated she had not struck R47 in any way, but had tried to lift R47's legs to help her lay down. The investigative report indicated the AP was NA-C. This report also included that NA-C had been implicated in a previous submitted report.

During interview 7/23/15, at 5:10 p.m., the SW stated the resident was unable to recall if the incident had happened, and said R47 had dementia. The SW said NA-C was not suspended during her investigation because it could "not be proved" that NA-C abused R47, and R47 continued to be on the work schedule. The SW said NA-C was counseled on how to provide cares for R47, and was asked for ideas from NA-C on how to keep R47 safe.

Review of the facility's MLHS-LTC NA/R Schedule indicated NA-C was not suspended pending the investigation of the incident dated 1/28/15 and NA-C was scheduled to work 1/28/15 and 1/29/15, while the investigation was in progress.

The investigation of this incident lacked timely interviewing of the NA-C. This incident occurred

revised to provide documentation space that clearly identifies the initial evaluators thoughts in regards to:
1) Reason for submission
2) Rationale for NOT submitting report beyond the facility
3) Action taken to Protect The Resident
The revision also provides the review team a means to clearly document their evaluation of the incident and any ACTION that they feel needs to be taken on but not limited on the following items: (Attachment F)
1)Timeliness of the report
2) Was Protection of the resident appropriate
3) Reportability decisions were appropriate
The vulnerable adult reporting process/guides located at each nurses' station will be updated by 8/25/15.
Responsible Person: LSW
8/19/15: 4- separate staff meeting were scheduled for 8/25/15 where the Administrator, DON and LSW will jointly provide nursing staff with training regarding the up to date changes that have been put into place to assist staff in identifying potential abuse and neglect, protecting the resident, discerning reportable injuries of unknown origin and reporting requirements.
This staff mtg will also cover the revisions to policies and available tools. All Nurses and NA-R staff will be strongly encouraged to attend, an attendance record will be kept

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F 225	Continued From page 6 on 1/24/15 but was not reported to the SA until 1/27/15. The investigation did not determine if the R47 was actually abused. The facility did not suspend NA-C or take action to protect residents, during the investigation. There was no indication that a thorough investigation was completed for R47. R47 had another facility Social Service Incident Referral Form (SSIRF), signed by RN-C indicated R47 was involved in an incident on "3/2/15 early a.m., of possible abuse or resident aggression." The SSIRF indicated: RN-C noted PCC notes (electronic progress notes) by LPN-B questioning verbal statements and other behaviors by resident [R47]; possible indication of maltreatment but just a likely symptoms of resident's dementia." The SSIRF further indicated the incident was discussed with Investigative Team on 3/3/15 at 8:30 a.m., and reported submitted to the state agency on 3/3/2015 at 12:30 p.m. The report also indicated NA-C was a person with credible knowledge of the situation. An initial Incident Report was submitted to the state agency on 3/3/15 regarding possible abuse of R47 on 3/2/15. The report referenced "two progress notes from NOC (night) shift early that a.m. of 3/2 that suggests either some behavioral concerns/dementia symptoms by resident [R47] at work or possible maltreatment of resident by staff." The report indicated uncertainty by staff on whether this was maltreatment, and "SW decided to go ahead and submit the allegation to [state agency]...." A nursing progress note, dated 3/2/215 at 4:03	F 225	and those staff unable to attend will be required to review materials presented and minutes of the meeting. A signature of completion will be required at the time of the review but no later than 9/1/15. Persons responsible: Administrator, DON and LSW 8/20/15: Protection of the Residents After review of all final evidence in the 2567 report NAR-C will be terminated 8/21/15. (NAR -C has been off since 8/10/15, earliest available meeting date for NAR-C prior to next scheduled shift is 8/21/15). (Attachment G) MONITORING 1. Audit (Attachment H) of each Social Service Incident Report Form will be reviewed for: timeliness of reporting, appropriateness of report, and actions taken to protect residents The audit will begin with any incident occurring after 8/21/15 and will include every incident reported for the next 3 months (ending 11/21/15) Responsible person: DON and LSW . Audit (Attachment I) of each Investigation Report will be completed to:Ensure thoroughness of investigations. The audit will begin with any incident occurring after 8/21/15 and will include every incident reported for the next 3 months (ends 11/21/15) Person(s) responsible: DON and LSW Both audit reports will be reported to the Quality Assurance Committee. (QA meets quarterly; Oct., Jan.,April and July).	

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F 225	Continued From page 7 a.m., written by LPN-B, indicated [R47] was "kicking at staff" and [R47] told staff "she was going to report 'her' to the nurse.." The note also indicated R47 told staff "you go around hitting everyone I heard.." On 3/2/15 at 6:03 a.m., a second progress noted indicated staff went to wipe dry blood off [R47's] lip, and [R47] hit staff. The note continued, that after R47 hit staff, R47 stated "I am going to report you for hitting me." Facility documentation did not indicate any action was taken to protect R47 and other residents during this investigation of potential abuse. Documentation of the investigation of this incident did not include determination the cause of R47's bloody lip, and there was no evidence of interview with the nursing assistant who provided cares for R47. The SSRIF also indicated there was no immediate reporting of this incident to the state agency or administrator. A final, Investigative Report was submitted to the state agency on 3/06/15 regarding the incident. The report indicated on 3/2/15 the "resident was interviewed by RN Care Coordinator (RN- A) and this SW. Resident denied remembering anything happening this past weekend during the daytime or the nighttime that upset her in any way.....She denied that anyone hits her or has been mean to her or that she has hit anyone else." The report also indicated "SW communicated with [LPN-B] about progress notes from 3/2/15 during night shift, "indicating the NAR was situating resident in the EZ lift (mechanical lift) to help her to the bathroom per resident's request and the NAR noticed resident's lip had been bleeding apparently cracked from being chapped with dry, winter air. [NA-C] told [R47] she was going wipe the dried blood off, but R47 struck out at NA,	F 225	Reference Checks: F225 (completed 8/19/15) Affects Residents R47,R12,R22 R39, R11, R66, R44, R8 and the Potential to affect all Residents 1. 8/18/15 The VA policy was updated (attachment C) indicating that HR would attempt to obtain information from previous employers and /or current employers during the pre-employment screening process including dates of employment, position held, and feedback on workplace performance 2. 8/18/19 A new Reference Check Form was developed (attachment J) which identifies documented reference checks with dates of employment, position held and feedback on workplace performance. 3. 8/18/15 The VP of HR provided Training to the HR recruiter on the revised VA Policy, and the new Reference Check Form. The Reference Check Form was implemented on 8/19/15 and will be used on all new hires going forward Monitoring: (attachment K) Responsible Party: VP of HR 4. Biweekly audits will be completed by the VP of HR or designee for for all new hires. The audit will include verification that the Reference Check form was completed for all new hires prior to their first day of employment. Audit reports will be reported to the Quality Assurance Committee.	

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F 225	Continued From page 8	F 225		

causing NA's glasses to dismount from her face." The report indicated NA-C re-approached later and assisted [R47] without incident. Later the same night, the NA was doing rounds and attempted to lift R47's feet back in bed, and resident kicked at NA-C. The report then referenced the allegations made by R47, that she was slapped. The report did not confirm a perpetrator in this incident. The report indicated R47's care plan was reviewed, and suggestions were made on how to approach R47 during cares. The report also indicated LPN-B was coached by the SW and DON on more thorough progress note charting, and further, that staff have been reminded to submit timely incident reports. The report included: "Something is just not resting well with this, and although there is no maltreatment of residents 'substantiated' in this particular incident, SW will continue to keep eyes and ears open for patterns and/or trends in conduct, etc."

Review of the facility's MLHS-LTC NA/R Schedule from February 23, 2015 to March 8, 2015, indicated NA-C was assigned to work 3/2/15 (the night of the alleged incident) and also worked on 3/3/15.

During interview 7/23/15, at 5:30 p.m. the SW stated, in review of this incident, she had "concerns with NA-C" but again could not prove she had really done anything wrong. The facility felt they could not substantiate the allegations against NA-C, and therefore did not warrant a "suspension or discipline" during the investigation. There was no indication that a thorough investigation was completed for R47.

(QA meets quarterly; Oct., Jan., April and July).

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R12's quarterly MDS dated 4/27/15 indicated she was moderately cognitively intact and needed extensive assist with dressing, bathing and grooming. R12's care plan dated 1/31/15, indicated she had potential for abuse from others related to cognitive impairment and limited mobility.

An initial Incident Report submitted to the state agency on 2/18/15, indicated that on 2/18/15, R12 was allegedly slapped, on her cheek, by a staff person who was attempting to administer medicine. The AP on the Incident Report was listed as unknown.

A final Investigative Report was submitted to the state agency on 2/23/15, regarding the incident. The report indicated R12 had made numerous allegations, but the only allegation that could be "tracked," was the one about someone slapping [R12] during the administration of Milk of Magnesia (MOM) that morning. Firstly, the report indicated the SW and DON proceeded to seek more information about who would have administered the MOM that morning. Per schedule, LPN-B and NA-C were the persons on duty. At 10:45 p.m. on 2/19/15, the DON and SW met with NA-C, who freely admitted having given MOM to R12 under direction of LPN-B. NA-C said "[R12] didn't want the MOM, and [R12] took the cup and threw the MOM all over." [NA-C] tried to clean it up off the bedding, resident's clothing and her face, using wet wipes." The report indicated NA-C denied slapping R12 in any way, but acknowledged wiping R12's face off with the wet ones. The report indicated, "It is possible this was perceived by [R12] as a slap." The SW asked NA-C to go to resident's room to see if resident could/would or would not identify

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her as the lady who slapped her, and NA-C agreed to do so. [R12] was sleeping soundly, however, so decided not awaken her. The report indicated "[NA-C's] willingness to go, however, leads SW to believe she [NA-C] is being truthful about not slapping resident." The report then indicated the DON spoke to LPN-B by phone on 2/23/15 at 3:20 p.m. LPN-C admitted asking NA-C to give MOM to R12 due to LPN being occupied elsewhere LPN-C also acknowledged that NA-C did report [R12's] claim of being slapped by a "blonde lady." The report then indicated staff have been alerted to have two persons present during cares with this resident and NA-C was instructed not to enter room without a colleague present.

During interview on 7/23/15, at 5:20 p.m. the SW stated she did not suspend NA-C since they could not prove NA-C slapped R12. The SW acknowledged NA-C had been involved in multiple incidents, and had "suspicions" with [NA-C], but did not feel "there was a reason to suspend" or provide disciplinary action to her during this investigation.

The investigation of this incident by the facility did not determine if R12 was slapped, nor was there follow up to have R12 positively identify the nursing assistant who provided cares. Although NA-C was instructed not to enter R12's room without a colleague present, the documentation offered no indication protections were put in place for other residents who were assisted by NA-C during this investigation of this incident, regardless of its outcome.

R22's admission MDS dated 4/24/15, indicated

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she had depression and a cerebral vascular accident (CVA), was moderately cognitively impaired and needed limited assist with transfers and extensive assist with toileting. R22's care plan dated 5/3/15, indicated she needed assist with toileting and transfers, had history of depression and sadness/isolating self. R22's care plan further indicated she had potential for abuse from others related to her general weakness, aches and pains. The care plan goal indicated "resident will remain safe and have needs met in a safe environment."

During observation on 7/20/15, at 5:54 p.m. R22 lifted her pant leg and displayed a bruise on her right shin measuring approximately 8 cm (centimeters) x 2 cm.. R22's bruise was black, fading to dark purple in color, with no apparent swelling

In an interview 7/20/15, at 5:54 p.m. R22 stated that she had been treated "roughly by the staff" and there is a staff member who works the night shift that is rough with her. R22 went on to state this staff member had "grabbed her arm when transferring" which caused a large bruise and also stated she had also hit her leg into the metal bar along the bottom of her bed.

The facility submitted an Incident Report to the state agency on 6/27/15, regarding an incident of alleged mistreatment and physical abuse of R22. The report also identified a bruise on R22's top right hand, measuring 5.5 cm x 5 cm, circular in shape; and a second bruise on R22's lower right shin 2.5 cm x 2.5 cm, circular in shape. The report was submitted by RN-D, and indicated that the initial reporter, NA-A, was also the alleged perpetrator in this incident. The report indicated,

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nursing assistant (NA)-C reported at 5:15 a.m., she had toileted R22, After being toileted, R22 told [NA-C] she was not coming back tonight,and that "some girl hurt her." NA-C asked who, and she [R22] stated she doesn't know who. The report then indicated that registered nurse (RN)-A, followed up with R22 in the morning and asked her to tell her what happened: "Resident reported she is not staying here again tonight and is not going to be treated like this anymore." R22 explained that staff was mad at her during the night for getting up to use the bathroom so many times, and that a "girl grabbed me and threw me into bed." R22 pointed out her hand hurt, and said "this is where she grabbed me," noted a bruise on top of right hand measures 5.5 cm (centimeters) x 5 cm circular is shape. R22 also reported when she threw me into bed, "I hit my leg on something metal;" a bruise noted on right outer lower shin measures 2.5 cm x 2.5 cm circular in shape. R22 could not recall who the girl was, nor her name. R22 thought it was around 0400. The report further indicated NA-C was the nursing assistant working on that wing during the night, and LPN-A was the nurse in charge. No other injuries noted, resident was reassured she will remain safe here, NA-C will be removed from working with resident at this time.

An additional Incident Report was submitted to the state agency on 7/1/15, which identified an injury of unknown source on R22's right forearm 8 x 5 cm, reddish purple in color, and oval in shape. The date of incident occurrence was unknown. The report indicated R22 said, "It happened a few days ago."

An Investigative Report was submitted to the state agency on 07/02/15, which combined the

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two submitted incident reports. The report indicated the DON and social worker SW "have tried to investigate this issue thoroughly and have been unable to substantiate who the alleged perpetrator [AP] is for certain, but have reached a conclusion there is reasonable suspicion a crime may have occurred in the form of assault, and are hence submitting a report also to law enforcement, in accordance with Elder Justice Act." Further, "The details of our internal investigation to the limits of our ability are being submitted to OHFC [Office of Health Facility Complaints] the state agency." The Investigative Report further indicated on 7/1/15, the DON and SW met with the AP, (NA-C) who stated R22 had requested to use the toilet 6-8 times that night (6/27/15). The report then indicated [SW and DON] "discussed with the AP the number of previous incidences involving this NAR, which can raise red flags re [regarding] her credibility, and she became somewhat defensive, face reddening and voice tightening, saying 'it's because I report things and others don't, so I end up getting in trouble.'" The report further listed, that during an interview 7/2/15 the DON and SW meet with NA-D, who stated she "reported having heard from resident (R22) on 6/30, that [R22] is afraid of the girl with the blonde hair and bangs, that she is not very nice, etc. The blond hair with the bangs fits description of NA-C. The report further included that NA-C had been "implicated in previous reports 75814, 78740, and 79433 with possible "power struggles" with residents, as she tries to perform cares; received coaching in these incidents. NA-C was also involved in report 79866 but was not specifically named as AP."

Although R22 had described NA-C as the staff member who had hurt her and NA-C was caring

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for her and received multiple large bruises, no disciplinary action was taken, NA-C was not suspended pending the investigation. Also, there was no indication that a thorough investigation was completed by the facility to include other interviews with staff and residents.

During interview on 7/23/15, at 4:50 p.m. the DON stated she has concerns that NA-C might be doing the accusations, but stated she was not certain. The DON said, "Staff monitor [NA-C] during the night shift," and "we have nurses on that do that." The DON stated the nurses were to report if they notice anything and have concerns.

In an interview on 7/23/15, at 5:03 p.m. the SW stated she did not talk with other residents or staff regarding abuse allegations by R22. The DON stated, "I don't generally do that, it's not a witch hunt." The DON said, "Just because their name keeps coming up does not make them guilty." The DON also said there were issues around "data privacy and confidentiality." SW further stated when something regarding abuse allegations come up over the weekend, the nurse on duty initiates the OHFC reporting. The SW said the nurse would talk to the resident, and address any immediate concerns. Regarding NA-C, the SW stated, "At times there have been several residents she is not allowed to care for, but that does change if, during the investigation the allegation is not substantiated." The SW further stated, in regard to NA-C, after the first allegation of abuse, "a lot of coaching was done." The SW also said the coaching for NA-C was "not intensive, and there was no improvement plan initiated and no documentation of education or mentoring done."

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During an interview on 7/23/15 at 5:10 p.m., the administrator said, "We have three young people working on nights, we can't suspend; there is not enough staff." The administrator further stated, " I feel the DON and SW did the right thing."

During an interview on 07/23/15, at 5:14 p.m. the DON stated NA-C was not suspended per the facility policy following the allegation made by R22 . She stated, "If I had suspended one, I would have had to suspend all three staff, then who would take care of the residents?"

During an interview on 07/24/15, 5:14 a.m., NA-E stated, " I don't work a lot of overnights unless I am mandated, but I do hear a few things." NA-E stated, "I have heard about people being super wet and I have heard that some of the girls are a little rough, but I can't tell you who." She further stated one of the residents mentioned about a girl being rough and leaving bruises. NA-E described the staff member as they were described by the resident and stated the resident said " the girl threw me into the chair because I had to go to the bathroom again." NA-E stated she does not see the nurse a lot on nights.

During interview on 7/24/15, at 5:25 a.m. LPN-H stated she works part time on the night shift. LPN-H stated she has heard from other NAs that NA-C is rough with the residents but had not witnessed it directly. LPN-H stated she was not aware that she was to monitor any staff during the night shift when she works. She further indicated she had heard R12 had reported that NA-C had slapped her and that NA-C no longer works on the North wing and thought the reason was because of the cat; not because she can not take care of any certain residents. She then

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stated the aides on the night shift don't work together they prefer to work on each unit alone.

INJURIES OF UNKNOWN ORIGIN

R39's annual MDS, dated 3/9/15, indicated she was moderately cognitively impaired. Her care plan, dated 3/30/15, indicated she required extensive assist with all activities of daily living, used a mechanical stand for transfers, and was at risk for abuse related to dementia.

Review of Social Service Incident Report Form, dated 10/7/14, indicated R39 had a large, dark purple bruise on the right upper portion of her buttock and that R39 was unaware of how the bruising occurred. The report indicated R39 had been lowered to floor by staff a few days prior to the bruise and indicated that may have caused the injury. The incident further indicated use of anticoagulant medication (used to prevent clotting) , other injuries/incidents over an unspecified times frame, and listed the injury as "minor." The injury was not reported to OHFC.

During an interview on 7/24/15, at 12:54 p.m., the DON)stated, when R39 had been lowered to the floor it would be hard to know if injury occurred during that event but stated, R39 bruised easily due to use of anticoagulant medication so therefore the injury was not considered reportable.

Although R39 was moderately impaired and unable to recall how the bruise occurred, there was no evidence that a more in-depth investigation was completed to determine the

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actual cause, nor was R39's injury of unknown origin reported to the state agency.

R11's quarterly MDS, dated 4/15/15, indicated she was moderately cognitively impaired. Care plan, dated 6/3/15, indicated R11 required extensive to total assist for all activities of daily living, was cognitively impaired, and at risk for abuse related to depression.

Review of three separate Social Services Incident Report Forms indicated R11 had injuries of unknown origin. An incident form dated 10/21/15, indicated R39 had a bruise to the top of her right hand that was dark purple in color and measured 8 cm x 8 cm. The report further indicated R11 was unable to state how the injury occurred, used blood thinners and described the injury as "minor." Another Social Services Report Form, dated 11/4/14, indicated R11 had bruising noted to her left temple and above her left eyebrow, and was unable to state the cause of the injury. A third incident report dated 12/18/14, indicated R11 had a bruise of unknown origin to her left inner knee, dark purple in color, measuring 1 x 1 3/4. (unit of measurement was not indicated). The report further indicated R11 was unable to report the cause of the injury, use of anticoagulant medications, and the injury was considered to be " minor." None of the three bruises were reported to OHFC.

During an interview on 7/24/15, at 12:54 p.m., SW stated, R11 "had more bruising than anyone I have ever known." She stated the bruise on R11's hand may have been caused by "recent trimming of [R11's] nails." Regarding the bruise noted to

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R11's temple and forehead, SW stated that nursing felt the bruising was due to placement of R11's nebulizer mask, however, SW interviewed R11 who reported that she slipped and fell on her way back from supper. SW further stated R11 did not ambulate, used a Hoyer lift for transfer and there were no records of any falls and indicated the bruising was likely due to placement of R11's nebulizer mask.

During an interview on 7/24/15, at 12:54 p.m., the DON stated R11 could reliably answer when asked if bruising was related to abuse, therefore, she felt the injury was not reportable.

Although R11 was identified to be moderately cognitively impaired, and had multiple bruises at different locations, and were unable to determine what happened, there was no indepth investigation completed to determine the actual causes of R11's bruises. The facility administrator was notified but none of these incidents were submitted to the state agency.

R66's quarterly MDS, dated 1/7/15, indicated she was moderately cognitively impaired. Care plan, dated 2/9/15, indicated R66 required extensive assist of two staff with use of mechanical lift for transfers, at risk for delirium, and at risk for abuse related to depression.

During review of a Social Service Incident Referral Form, dated 2/3/15, a facility progress noted indicated R66 had bruising along both arms from her hands to her shoulders. The form further indicated R66 was unable to state the cause of the injury and that the injury was assessed to be "minor." The injury was not reported to OHFC.

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During an interview on 7/24/15, at 12:54 p.m., SW stated, the bruises were noted while the DON was reviewing a progress note and she spoke with nursing and determined the bruising was assessed to be a minor injury and therefore not reportable to to OHFC.

During an interview on 7/24/15, at 12:54 p.m., the DON stated, R66 used a Hoyer lift (mechanical lift) and did not always cooperate in lift, occasionally "flailing her arms." She further stated, R66 was confused and that it would be "hard to say if R66 would have been able to to talk about how the bruising occurred after any time had passed."

Although R66 had bilateral bruising from her hands to her shoulders, the injury was unwitnessed and the resident was unable to identify what happened. The facility had not immediately reported the incident to the state agency nor was a thorough investigation completed to determine if R66 was "flailing her arms" while using the mechanical lift.

R44's annual MDS, dated 6/9/15, indicated she was severely cognitively impaired. Care plan, dated 7/10/15, indicated R44 required extensive assist with activities of daily living, and was at risk for abuse related to short term memory loss and impaired decision making skills.

Review of Social Service Incident Referral Form, dated 6/15/15, indicated R44 had a purple bruise on her posterior forearm measuring 6.3 cm x 7 cm that was found during her bath. The incident

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form indicated R66 did not state the cause of injury and that the injury was determined to be "minor."The bruise was not reported to OHFC.

During an interview on 7/24/15, at 12:54 p.m., SW stated, on 8/18/14, staff reported R8 had a bruise measuring 8.5 cm in length between her thumb and forefinger from the base of the thumb to her wrist. She stated the reporting nurse did the initial evaluation and determined the bruising resulted from R8 wringing her hands, and the wringing of her hands was witnessed by staff. She further stated the injury was not reportable due to staff witness of the potential cause. A Social Services Incident Referral form was requested for this injury but was not received.

During an interview on 7/24/15, at 12:54 p.m., SW stated when making a determination of whether or not to report an injury to OHFC, she refers to statutes, and uses a decision tree. SW also stated that she looks at whether a resident is able to explain the injury or if someone else saw it, and if there is a history of other recent falls and/or injuries. She further stated, if the nurses indicated minor injury or injury not suspicious in nature or location, it does not need to be reported.

During an interview on 7/24/15, at 12:54 p.m., the DON stated, there was no criteria for determining whether an injury was minor vs major. She further stated, the nurse finding the injuries did initial evaluation to determine the above injuries to be minor. The DON stated she would use the nurses judgement when determining if an injury was minor or major and that the RN in charge

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

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followed up on the injuries. However, she stated there was no charting in the clinical record that would show evidence that follow up had been completed.

Even though R44 was assessed to be severely cognitively impaired, had an injury of "unknown" origin, on the posterior of her arm. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency.

R8's quarterly minimum data set (MDS) identified her to be severely cognitively impaired and requiring assist of two staff for activities of daily living. CP dated 5/15/15 indicated R8 required extensive assist for activities of daily living and was at risk for abuse related to diagnosis of dementia.

A review of SSIRF dated 8/18/14, indicated R8 had a bruise measuring 8.5 cm in length between her thumb and forefinger from the base of her thumb to her wrist. The reporting nurse did the initial evaluation and determined the bruising resulted from R8 wringing her hands, and the wringing of her hands was witnessed by staff.

During an interview on 7/24/15, at 12:54 p.m., SW stated, the injury was not reportable due to staff witness of the potential cause. No further investigation of the injury was completed. The facility administrator was notified of the injury but a report was not made to the state agency. A Social Services Incident Referral form was requested for this injury but was not received.

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Although R8 had severe cognitive impairment, and had a bruise 8.5 cm between her thumb and forefinger from the base of her thumb to her wrist. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency.

Review of the facility Vulnerable Adult Policy, revised 7/15, indicated: "It is the policy of MLHS (Mille Lacs Health System) to protect adults who are vulnerable to abuse (including verbal, physical, mental psychosocial/emotional, and sexual abuse)..." The policy further indicated: "protection will include abuse prevention plans, individual abuse prevention plans, internal reporting of all cases of suspected abuse, neglect, or financial exploitation, and external reporting to the Common Entry Point (CEP) of substantiated incidents of maltreatment." In regard to investigation of a reportable incident, the policy stated: "All alleged violations are thoroughly investigated. The facility must prevent further potential abuse while the investigation is in progress." Under the "Protection for Resident or Patient" section, the policy directed that "The alleged perpetrator (AP) will be removed from the situation. If the AP is an employee, they will be suspended until the investigation is completed," and further, "Disciplinary action will be carried out up to and including dismissal of employee/employees as appropriate." The Policy defined Injury of Unknown Origin as "...source of the injury was not observed and injury as suspicious." The policy did not expound on this definition top include CMS definitions. In regard to screening of potential employees, the policy directed "MLHS will attempt to obtain information from previous employers and/or current

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F 225	Continued From page 23 employers."	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement their Vulnerable Adult Policy to ensure all allegations of abuse, neglect, mistreatment and injuries of unknown origin were immediately reported to the administrator and state agency, were thoroughly investigated, and residents were protected during the investigations for 8 of 15 residents' (R47, R12, R22, R39, R11, R66, R44 and R8) allegations reviewed. In addition, the facility failed to conduct reference checks according to their policy for 4 of 5 newly hired employees (NA-A, NA-B, DA-A and RN-B). This had the potential to effect all 50 residents who resided in the facility, and resulted in substandard quality of care under resident behavior and facility practices. Findings include: The facility Vulnerable Adult Policy, revised 7/15, indicated: "It is the policy of MLHS (Mille Lacs Health System) to protect adults who are vulnerable to abuse (including verbal, physical, mental psychosocial/emotional, and sexual	F 226	Investigation and Protection: Affects residents R47, R12, R22, R39, R11, R66, R44, R8 with the Potential to affect All Residents. Injuries of Unknown Origin: Affects residents R39, R11, R66, R44, R8 with the Potential to affect All Residents. Corrections support investigation, protection and injuries of unknown origin 7/24/15 @ 10:15 PM: A Performance Improvement Plan was delivered and implemented effective immediately with NA-C. (Attachment B). One said measurement included NO complaints regarding care action during the shift. Failure to meet this goal will result in further disciplinary action up to termination. 7/29/15 In order to ensure the protection and safety of R22 it was decided that at this time 2 staff would be required in the room when providing care. This was discussed	8/21/15

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F 226	Continued From page 24 abuse)..." The policy further indicated: "protection will include abuse prevention plans, individual abuse prevention plans, internal reporting of all cases of suspected abuse, neglect, or financial exploitation, and external reporting to the Common Entry Point (CEP) of substantiated incidents of maltreatment." In regard to investigation of a reportable incident, the policy stated: "All alleged violations are thoroughly investigated. The facility must prevent further potential abuse while the investigation is in progress." Under the "Protection for Resident or Patient" section, the policy directed: "The alleged perpetrator (AP) will be removed from the situation. If the AP is an employee, they will be suspended until the investigation is completed," and further, "Disciplinary action will be carried out up to and including dismissal of employee/employees as appropriate." INVESTIGATION AND PROTECTION During interview 7/23/15, at 5:09 p.m. with social worker (SW) stated that nursing assistant (NA)-C has been implicated in at least four incident reports from February 2015 to July 2015 of alleged abuse, and neglect. Review of facility Incident and Investigation reports from 2/1/2015 to 7/20/2015 for NA-C identified the following: R47's quarterly minimum data set (MDS) dated 2/17/15, indicated she was moderately cognitively intact and needed extensive assistance in ADLs. R47's care plan dated 2/26/15, indicated she had dementia and needs assist with dressing, grooming and bathing. The care plan further indicated she had slight alteration in cognition	F 226	at R22's Care Conference and was approved by both R22 and her family. 8/15/15 Existing VA tracking log revised to include identity of alleged perpetrators to better identify trends occurring, including those incidents that have been ¿unable to substantiate.¿ The Log will be updated at the time investigation results are submitted to OHFC and again when the investigation is closed. Upon Closure of each incident the VA Log will be electronically forwarded by LSW to administrator to assure the administrator is kept informed of the FULL STATUS of the investigations with regards to timeliness of report submissions, final disposition and actions taken with regards to alleged perpetrator. Person(s) responsible: LSW On 8/17/15: Facility wide Vulnerable Adult Policy (Attachment C) revised to delineate protections for residents This includes CMS language defining injuries of unknown source. On 8/18/15: Administrator and Medical Director sent a letter (Attachment D) to all residents and/or their representatives regarding survey findings; how, what and how often we educate staff and the facility¿s commitment to protecting vulnerable adults. A flier with information on warning signs of abuse and neglect, and a copy of the staff education over the last 12 months were included with the letter.	

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F 226	Continued From page 25 related to dementia and that resident will continue to be oriented to person, place and time. A facility Social Service Incident Referral Form (SSIRF) indicated licensed practical nurse (LPN)-D verbally reported to the social worker (SW) on 1/27/2014, at 4 p.m., an incident that occurred during the night shift on 1/24/2015. The SSIRF, dated 1/27/15, indicated: "Alleged altercation/conflict between res [resident] & aides resulting in resident slapping aide and stating 'I didn't hit you, you hit me you liar.'" The SSIRF also indicated, "LPN separated aide & resident, assisted res to bed, escorted aide to hallway to inquire what happened." The SSIRF also indicated the incident required "further investigation and/or reporting" to the state agency, and this was signed by the SW on 1/28/15. A review of Mille Lacs Nursing Home Progress Notes, dated 1/28/15, written by LPN-D indicated: "This nurse was in a res. room, 5 rooms away from where the incident happened, but heard a distinct smack. Followed by a woman's out cry. This nurse then got a call on the walkie [walkie-talkie] from the aide (nursing assistant, NA)." The [NA] stated (in her words) "On 2 a.m. rounds, I went to check resident in room 45-1 (room 45, bed 1) and woke up resident in 45-2 [R47] in the process. I told [R47] the time and said she should lay back down and try and get some sleep until coffee time." [R47] said "No, I want to sit up I'm waiting." NA said "No lets lay down" and NA went to pick up [R47's] feet to bring them in bed and [R47] swung and hit me in the head, fairly hard. I [NA] yelled out "ow" and NA said "why did you hit me, [R47] said, 'I didn't, you hit me you liar' then [NA] walked out and	F 226	On 8/19/15 Social Service Incident Reporting Form (Attachment E) was revised to provide documentation space that clearly identifies the initial evaluators thoughts in regards to: 1) Reason for submission 2) Rationale for NOT submitting report beyond the facility 3) Action taken to Protect The Resident The revision also provides the review team a means to clearly document their evaluation of the incident and any ACTION that they feel needs to be taken on but not limited on the following items: (Attachment F) 1)Timeliness of the report 2) Was Protection of the resident appropriate 3) Reportability decisions were appropriate The vulnerable adult reporting process/guides located at each nurses' station will be updated by 8/25/15. Responsible Person: LSW 8/19/15: 4- separate staff meeting were scheduled for 8/25/15 where the Administrator, DON and LSW will jointly provide nursing staff with training regarding the changes that have been put into place to assist staff in identifying potential abuse and neglect, protecting the resident, discerning reportable injuries of unknown origin and reporting requirements. This staff mtg will also cover the revisions to policies and available tools. All Nurses and NA-R staff will	

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F 226	Continued From page 26 walkie the nurse...." This nurse [LPN-D] asked the res. why she hit the aide. Res. [R47] stated that the aide hit her." The nursing note did not identify the nursing assistant by name. A facility email, written by the SW, dated 1/28/2015, indicated the SW had been verbally informed by LPN-D of R47 being in a conflict with a nursing assistant. The email indicated there was a progress note of the incident, but no further "incident report form." The email indicated the SW further reviewed the progress notes, and because the notes indicated "the resident allegedly struck a NAR [nursing assistant] and also that the resident claimed at the time that the NAR struck her, the incident DOES need to be reported" to the state agency. An Incident Report submitted to the state agency on 1/28/15, indicated: "An incident was verbally reported to this SW in the late afternoon 1/27/15..." and further that R47 had a conflict "this past weekend" with a nursing assistant. Following a review of the related progress notes by the "Stand Up Team" and "Behavior Management Team", it was originally determined incident was due to [R47's] "dementia symptoms..." The report referred to a nursing progress note which indicated that [R47] "claimed at the time that the NAR struck her," thus requiring a report to the state agency, and "an internal investigation done accordingly as per policy." The alleged perpetrator (AP) was unidentified. A review of the SSIRF, the internal email, and the initial report submitted to the state agency indicated an incident occurred sometime during the night shift/early morning hours of 1/25/14.	F 226	be strongly encouraged to attend, an attendance record will be kept and those staff unable to attend will be required to review materials presented and minutes of the meeting. A signature of completion will be required at the time of the review but no later than 9/1/15. Persons responsible: Administrator, DON and LSW 9/20/15: Protection of the Residents After review of all final evidence in the 2567 report NAR-C will be terminated 8/21/15. (NAR-C has been off since 8/10/15, earliest available meeting date for NAR-C prior to next scheduled shift 8/21/15. (Attachment G) MONITORING 1. Audit (Attachment H) of each Social Service Incident Report Form will be reviewed for: timeliness of reporting, appropriateness of report, and actions taken to protect residents The audit will begin with any incident occurring after 8/21/15 and will include every incident reported for the next 3 months (ending 11/21/15) Responsible person: DON and LSW 2. Audit (Attachment I) of each Investigation Report will be completed to:Assure thoroughness of investigations. The audit will begin with any incident occurring after 8/21/15 and will include every incident reported for the next 3 months (ending 11/21/15) Person(s) responsible: DON and LSW Both audit reports will be reported to	

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F 226	Continued From page 27 The report also indicated the incident was first reported, and made known to the SW on late afternoon of 1/27/2014, (two days after the incident) and reported to the state agency on 1/28/2015 (three days after the incident allegedly occurred). There was no indication this incident was reported immediately to the administrator and state agency. Additionally, the investigation of this incident: lacked timely interviewing of NA-C, and other involved staff, and potentially affected residents; did not provide evidence R47 was thoroughly investigated for injuries; and lacked evidence of action to protect residents during the investigation. A final Investigative Report was submitted to the state agency on 2/2/15. The report indicated the SW met with R47 "on the a.m. of 1/28/15 and 1/30/15," and "Resident unable to recall any incidents of concern with any aides the previous weekend." The SW was unable to speak with NA-C, (identified as the nursing assistant involved) until 2/2/15 (7 days after the SW learned of the incident) "in part due to her work schedule not coinciding with the SW." SW spoke with NA-C by phone on 2/2/15, at 10:45 p.m. NA-C "acknowledged the incident happened as described" by LPN-D's note, and further, "[NA-C] saying she had not struck resident in any way, but had merely tried to lift [R47's] legs to help her lay back down..." The report indicated "There is no apparent evidence of NAR striking resident." The investigative report indicated the alleged perpetrator was NA-C. This report also included that NA-C had been implicated in a previous submitted report. During an interview 7/23/15, at 5:10 p.m., the SW	F 226	the Quality Assurance Committee. (QA meets quarterly; Oct., Jan., April and July). Reference Checks: F225 Corrected 8/19/15 Affects Residents R47,R12,R22 R39, R11, R66, R44, R8 and the Potential to affect all Residents 1. 8/18/15 The VA policy was updated (Attachment C) indicating that HR would attempt to obtain information from previous employers and /or current employers during the pre-employment screening process including dates of employment, position held, and feedback on workplace performance 2. 8/18/19 A new Reference Check Form was developed (Attachment J) which identifies documented reference checks with dates of employment, position held and feedback on workplace performance. 3. 8/18/15 The VP of HR provided Training to the HR recruiter on the revised VA Policy, and the new Reference Check Form. The Reference Check Form was implemented on 8/19/15 and will be used on all new hires going forward Monitoring: (attachment K) Responsible Party: VP of HR 4. Biweekly audits will be completed by the VP of HR or designee for for all new hires. The audit will include verification that the Reference Check form was	

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F 226	Continued From page 28 stated in the investigation, R47 was unable to recall if the incident had happened, and that R47 had dementia. The SW said NA-C was not suspended during her investigation because it could not be proven that NA-C abused R47, and NA-C continued to be on the work schedule. The SW said NA-C was counseled on how to provide cares for R47, and was asked for ideas from NA-C on how to keep R47 safe. Review of the facility's MLHS-LTC NA/R Schedule from January 26, 2014 to February 8, 2015, indicated NA-C worked on the night shift on 1/28/15 and 1/29/15, while the investigation of this incident was in progress. R47 had another facility Social Service Incident Referral Form (SSIRF), signed by RN-C indicated R47 was involved in an incident on "3/2/15 early a.m., of possible abuse or resident aggression." The SSIRF indicated: RN-C noted PCC notes (electronic progress notes) by LPN-B questioning verbal statements and other behaviors by resident [R47]; possible indication of maltreatment but just a likely symptoms of resident's dementia." The SSIRF further indicated the incident was discussed with Investigative Team on 3/3/15 at 8:30 a.m., and reported submitted to the state agency on 3/3/2015 at 12:30 p.m. The report also indicated NA-C was a person with credible knowledge of the situation. An initial Incident Report was submitted to the state agency on 3/3/15 regarding possible maltreatment of R47 on 3/2/15. The report referenced "two progress notes from NOC (night) shift early that a.m. of 3/2 that suggests either	F 226	completed for all new hires prior to the first day of employment. Audit reports will be reported to the Quality Assurance Committee. (QA meets quarterly; Oct., Jan., April and July).	

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some behavioral concerns/dementia symptoms by resident [R47] at work or possible maltreatment of resident by staff." The report indicated uncertainty by staff on whether this was maltreatment, and "SW decided to go ahead and submit the allegation to [state agency]...."

A nursing progress note, dated 3/2/215 at 4:03 a.m., written by LPN-B, indicated [R47] was "kicking at staff" and [R47] told staff "she was going to report 'her' to the nurse.." The note also indicated R47 told staff "you go around hitting everyone I heard.." On 3/2/15 at 6:03 a.m., a second progress noted indicated staff went to wipe dry blood off [R47's] lip, and [R47] hit staff. The note continued, that after R47 hit staff, R47 stated "I am going to report you for hitting me."

Facility documentation did not indicate any action was taken to protect R47 and other residents during this investigation of potential abuse. Documentation of the investigation of this incident did not include determination the cause of R47's bloody lip, and there was no evidence of interview with the nursing assistant who provided cares for R47. The SSRIF also indicated there was no immediate reporting of this incident to the state agency or administrator.

A final, Investigative Report was submitted to the state agency on 3/06/15 regarding the incident. The report indicated on 3/2/15 the "resident was interviewed by RN Care Coordinator (RN- A) and this SW. Resident denied remembering anything happening this past weekend during the daytime or the nighttime that upset her in any way.....She denied that anyone hits her or has been mean to her or that she has hit anyone else." The report also indicated "SW communicated with [LPN-B]

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about progress notes from 3/2/15 during night shift, "indicating the NAR was situating resident in the EZ lift (mechanical lift) to help her to the bathroom per resident's request and the NAR noticed resident's lip had been bleeding apparently cracked from being chapped with dry, winter air. [NA-C] told [R47] she was going wipe the dried blood off, but R47 struck out at NA, causing NA's glasses to dismount from her face." The report indicated NA-C re-approached later and assisted [R47] without incident. Later the same night, the NA was doing rounds and attempted to lift R47's feet back in bed, and resident kicked at NA-C. The report then referenced the allegations made by R47, that she was slapped. The report did not confirm a perpetrator in this incident. The report indicated R47's care plan was reviewed, and suggestions were made on how to approach R47 during cares. The report also indicated LPN-B was coached by the SW and DON on more thorough progress note charting, and further, that staff have been reminded to submit timely incident reports. The report included: "Something is just not resting well with this, and although there is no maltreatment of residents 'substantiated' in this particular incident, SW will continue to keep eyes and ears open for patterns and/or trends in conduct, etc."

Review of the facility's MLHS-LTC NA/R Schedule from February 23, 2015 to March 8, 2015, indicated NA-C was assigned to work 3/2/15 (the night of the alleged incident) and also worked on 3/3/15.

During interview 7/23/15, at 5:30 p.m. the SW stated, in review of this incident, she had "concerns with NA-C" but again could not prove

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she had really done anything wrong. The facility felt they could not substantiate the allegations against NA-C, and therefore did not warrant a "suspension or discipline" during the investigation. There was no indication that a thorough investigation was completed for R47.

R12's quarterly MDS dated 4/27/15 indicated she was moderately, cognitively intact and needed extensive assist with dressing, bathing and grooming. R12's care plan dated 1/31/15, indicated she had potential for abuse from others related to cognitive impairment and limited mobility.

A facility Social Service Incident Referral Form (SSIRF), signed by the SW 2/18/15 at 4:15 p.m., indicated there was an incident on "2/18/2015 early A.M.", which alleged "Abuse." The incident was described as: "[NA)-I] asked SW to meet w/ Res re some issues. 9:30 a.m. Res told SW 'I want to go home, they're mean to me here.' 'The lady with the ponytail hurt me when she clean me up yesterday', and 'The other lady slapped me when she tried to make me drink white stuff.' At 4p.m. resident [R12] was still claiming similar concerns." The SSIRF also indicated the following: an internal email report was completed on 2/18/15; that the report of alleged abuse was received by the SW in person, no date or time listed; the incident was discussed with "Investigative Team" on 2/18/15 at 0833; and that the state agency initial report was submitted on 2/18/15 (no time indicated).

An initial Incident Report submitted to the state agency on 2/18/15, indicated on 2/18/15, R12

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was "slapped on her cheek by a staff person early this morning while staff person was trying to get her to take some medicine." The report indicated R12 had no apparent injuries, and "has been consistent with this claim throughout the day..." The report also indicated "a full internal investigation is warranted." The "alleged perpetrator" on the report form was listed as "unknown."

A review of the SSIRF, and the initial report to the State Agency indicated, that although this incident occurred in the early morning of 2/18/15, and possibly earlier, no action was taken by the facility or staff until it was discussed later that morning on 2/18/15. There was no indication the incident was immediately reported to state agency and administrator. Further, the investigation documentation of this incident did not indicate if R12 was slapped; and there was no follow up to have R12 positively identify the nursing assistant, (possibly NA-C) who provided her cares that day. Although NA-C was instructed not to enter R12's room without a colleague present, the documentation offered no indication protections were put in place for other residents who were assisted by NA-C during the investigation of this incident, regardless of its outcome.

A final Investigative Report was submitted to the state agency on 2/23/15. The final report indicated the "Initial Reports submitted to [state agency] ...at 4 p.m.," on 2/18/15, and also a call was made to local law enforcement. The report indicated R12 had made numerous allegations, but the only allegation that could be "tracked, was the one about someone slapping her during the administration of Milk of Magnesia (MOM) that

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morning (the white stuff)." The report indicated SW and DON proceeded to seek more information about who would have administered the MOM that morning. The report identified, according to the schedule, LPN-B and NA-C were the persons on duty. Further, the report indicated, "DON and SW met with [NA-C], who freely admitted having given MOM upon the direction of [LPN-B]." The report continued, "[NA-C] said resident didn't want the MOM, and resident took the cup and threw the MOM all over." and "[NA-C] tried to clean it up off the bedding, resident's clothing and her face, using wet wipes." The report indicated "[NA-C] denied slapping resident in any way, but acknowledged wiping R12's face off with the wet ones." The report indicated "It is possible this was perceived by [R12] as a slap." Next, the report indicated, the SW asked NA-C to go to resident's room to see if resident could or would identify her as the lady who slapped her, and NA-C agreed to do so. "[R12] was sleeping soundly, however, so decided not awaken her." The report indicated "NA-C's willingness to go, however, leads SW to believe she [NA-C] is being truthful about not slapping resident." The report indicated the DON spoke to LPN-B by phone on 2/23/15 at 3:20 p.m. LPN-C admitted asking NA-C to give MOM to R12 due to LPN-C being occupied elsewhere LPN-C also acknowledged that NA-C did report (R12's) claim of being slapped by a "blonde lady." The report then indicated staff have been alerted to having "two persons present" during cares with this resident and NA-C was instructed not to enter room without a colleague present.

During interview on 7/23/15, at 5:20 p.m. the SW stated she did not suspend NA-C since "they could not prove [NA-C] slapped [R12.]" The SW

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acknowledged NA-C had been involved in multiple incidents, and had "suspicions" with [NA-C], but did not feel "there was a reason to suspend" or provide disciplinary action to her during this investigation.

Review of the facility's MLHS-LTC NA/R Schedule from February 9, 2015 to February 22, 2015, indicated NA-C worked on 2/17/15 through 2/22/2015, that is on the date of the alleged incident, and during the subsequent investigation. There was no indication a thorough investigation was completed for R12.

R22's admission MDS dated 4/24/15, indicated she had depression and a cerebral vascular accident (CVA), and was moderately cognitively impaired and needed limited assist with transfers and extensive assist with toileting. R22's care plan dated 5/3/15, indicated she needed assist with toileting and transfers, had history of depression and sadness/isolating self. R22's care plan further indicated she had potential for abuse from others related to her general weakness, aches and pains. The care plan goal indicated "resident will remain safe and have needs met in a safe environment."

During observation on 7/20/15 at 5:54 p.m., R22 lifted her pant leg and displayed a bruise on her right shin measuring approximately 8 cm (centimeters) x 2 cm. R22's bruise was noted to be black, fading to dark purple in color, with no apparent swelling. In an interview 7/20/15, at 5:54 p.m. R22 stated that she had been treated "roughly by the staff" and there is "a staff member who works the night shift that is rough with her."

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R22 went on to state this staff member had "grabbed her arm when transferring" which caused a large bruise and also stated she had also hit her leg into the metal bar along the bottom of her bed.

The facility submitted an Incident Report to the state agency on 6/27/15 regarding an incident of alleged mistreatment and physical abuse of R22. The report also identified a bruise on R22 top right hand, measuring 5.5 cm x 5 cm, circular in shape; and a second bruise on R22's lower right shin 2.5 cm x 2.5 cm, circular in shape. The report was submitted by RN-D, and indicated that the initial reporter, NA-C, was also the alleged perpetrator in this incident. The report indicated, nursing assistant (NA)-C reported at 5:15 a.m., she had toileted R22, after being toileted, R22 told [NA-C] she was not coming back tonight,and that "some girl hurt her." NA-C asked who, and she [R22] stated she doesn't know who. The report then indicated that registered nurse (RN)-A, followed up with R22 in the morning and asked her to tell her what happened: "Resident reported she is not staying her again tonight and is not going to be treated like this anymore." R22 explained that staff was mad at her during the night for getting up to use the bathroom so many times, and that a "girl grabbed me and threw me into bed." R22 pointed out her hand hurt, and said "this is where she grabbed me," noted a bruise on top of right hand measures 5.5 cm (centimeters) x 5 cm circular is shape. R22 also reported when she threw me into bed, "I hit my leg on something metal" a bruise noted on right outer lower shin measures 2.5 cm x 2.5 cm circular in shape. R22 could not recall who the girl was, nor her name. R22 thought it was around 0400. The report further indicated NA-C

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was the nursing assistant working on that wing during the night, and LPN-A was the nurse in charge. No other injuries noted, resident was reassured she will remain safe here, NA-C will be removed from working with resident at this time.

An additional Incident Report was submitted to the state agency on 7/1/15, which identified an injury of unknown source on R22's right forearm "8 x 5 cm, reddish purple in color and oval in shape." The date of incident occurrence was unknown. The report indicated R22 said "It happened a few days ago."

An Investigative Report was submitted to the state agency on 07/02/15, which combined two submitted incident reports dated 6/27/15 and 7/1/15. The report indicated the director of nursing (DON) and social worker (SW) "have tried to investigate this issue thoroughly and have been unable to substantiate who the alleged perpetrator [AP] is for certain, but have reached a conclusion there is reasonable suspicion a crime may have occurred in the form of assault, and are hence submitting a report also to law enforcement, in accordance with Elder Justice Act." Further the report indicated, "The details of our internal investigation to the limits of our ability are being submitted to OHFC and the state agency." The Investigative Report further indicated on 7/1/15, the DON and SW met with the AP, (NA-C) who stated R22 had requested to use the toilet 6-8 times that night (6/27/15). The report then indicated [SW and DON] "discussed with the AP the number of previous incidences involving this NAR, which can raise red flags re her credibility, and she became somewhat defensive, face reddening and voice tightening, saying 'it's because I report things and others

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don't, so I end up getting in trouble.' " The report further listed, that during an interview 7/2/15 the DON and SW meet with NA-D, who stated she "reported having heard from resident (R22) on 6/30, that [R22] is afraid of the girl with the blonde hair and bangs, that she is not very nice, etc. The blond hair with the bangs fits description of NA-C. The report further included that NA-C had been "implicated in previous reports 75814, 78740, and 79433 with possible "power struggles" with residents, as she tries to perform cares; received coaching in these incidents. NA-C was also involved in report 79866 but was not specifically named as AP."

Although R22 had described NA-C as the staff member who had hurt her and NA-C was caring for her and received multiple large bruises, the incident documentation indicated no action taken to protect residents during investigation of these incidents. Also, there was no indication that a thorough investigation was completed that included other interviews with staff and residents.

During interview on 7/23/15, at 4:50 p.m. the DON stated she "has concerns that NA-C might be doing the accusations," but stated she "was not certain." The DON said, "staff monitor [NA-C] during the night shift," and also "we have nurses on that do that." The DON stated the nurses were to report to her if they notice anything and have concerns.

In an interview on 7/23/15, at 5:03 p.m., the SW stated she "did not talk with other residents or staff regarding abuse allegations by [R22]." The DON stated, "I don't generally do that, it's not a witch hunt." The DON said, "Just because their name keeps coming up does not make them

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guilty." The DON also said there were issues around "data privacy and confidentiality." SW further stated, when something regarding abuse allegations come up over the weekend, the nurse on duty initiates the OHFC reporting. The SW said the nurse would talk to the resident, and address any immediate concerns. Regarding NA-C, the SW stated, "At times there have been several residents she is not allowed to care for, but that does change if, during the investigation the allegation is not substantiated." The SW further stated, in regard to NA-C, after the first allegation of abuse, " a lot of coaching was done." The SW also said the coaching for NA-C was "not intensive, and there was no improvement plan initiated and no documentation of education or mentoring done."

During an interview on 7/23/15 at 5:10 p.m., the administrator said, "We have three young people working on nights, we can't suspend; there is not enough staff." The administrator further stated, " I feel the DON and SW did the right thing."

During an interview on 07/23/15, at 5:14 p.m., the DON stated NA-C was not suspended per the facility policy following the allegation made by R22 . She stated, "If I had suspended one, I would have had to suspend all three staff, then who would take care of the residents?"

During an interview on 07/24/15 5:14 a.m., NA-E stated, " I don't work a lot of overnights unless I am mandated, but I do hear a few things." NA-E stated, "I have heard about people being super wet and I have heard that some of the girls are a little rough, but I can't tell you who." She further stated, one of the resident mentioned about a girl being rough and leaving bruises. NA-E described

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the staff member as they were described by the resident and stated the resident said " the girl threw me into the chair because I had to go to the bathroom again." NA-E stated she does not see the nurse a lot on nights.

During interview on 7/24/15, at 5:25 a.m. LPN-H stated she works part time on the night shift. LPN-H stated she has heard from other NAs that NA-C is rough with the residents but had not witnessed it directly. LPN-H stated she is not aware that she is to monitor any staff during the night shift when she works. She further indicated she had heard R12 had reported that NA-C had slapped her and also that NA-C no longer works on the North wing and thought the reason was because of the cat not because she can not take care of any certain residents. She then stated the aides on the night shift don't work together they prefer to work on each unit alone.

INJURIES OF UNKNOWN ORIGIN

The facility Vulnerable Adult Policy, revised 7/15, defined Injury of Unknown Origin as "...source of the injury was not observed and injury as suspicious." The policy did not expound on this definition to include criteria from the CMS interpretive guidance.

R39's annual MDS, dated 3/9/15, indicated she was moderately, cognitively impaired. The CP, dated 3/30/15, indicated R39 required extensive assist with all activities of daily living (ADLs), used a mechanical stand for transfers, and was identified at risk for abuse, because of dementia.

A review of SSIRF dated 10/7/14, indicated R39

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had a large, dark purple bruise on the right upper portion of her buttock, and it was an "unknown" injury, and R39 was "unaware" of how the bruising occurred. The SSIRF also indicated R39 "a few days ago had been lowered to floor due to not standing when transferring & then lifted with Hoyer (a mechanical lift) Possible cause." The SSRIF further indicated R39 used a medication that could explain bruising, and also that R39's chart contained "falls or other recent incidents that could likely have produced the injury." The SSIRF indicated R39's injury was "minor" and not reported to the state agency. No further investigation was completed for this incident even though there was no indication R39 had struck any objects or the floor as she was lowered to the ground.

During an interview on 7/24/15, at 12:54 p.m., the DON stated, when R39 had been lowered to the floor "it would be hard to know if injury occurred during that event." The DON said R39 bruised easily due to use of anticoagulant medication, so therefore the injury was "not considered reportable."

Although R39 was moderately impaired and unable to recall how the bruise occurred, there was no evidence that a more in-depth investigation was completed to determine the actual cause, nor was R39's injury of unknown origin reported to the state agency.

R11's quarterly MDS, dated 4/15/15, indicated she was moderately, cognitively impaired. The CP, dated 6/3/15, indicated R11 required extensive to total assist for all ADLs, and was at

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risk for abuse related to depression.

A review of SSIRF dated 10/21/15, indicated R39 had a bruise to the top of her right hand, dark purple in color, and measured 8 cm x 8 cm. The SSIRF indicated R11 was unable to state how the injury occurred, but R11 used anticoagulant medication, and R11's bruise was described as "minor." The facility administrator was notified but no report was made to the state agency.

A second SSIRF, dated 11/4/14, indicated R11 had bruising noted to her left temple and above her left eyebrow. The SSIRF indicated R11 was unable to state the cause of the injury. The facility administrator was notified, but the injury was not reported to the state agency.

A third SSIRF dated 12/18/14, indicated R11 had a bruise of unknown origin to her left inner knee, dark purple in color, and measuring 1 x 1 3/4 inches. The SSIRF indicated the injury was "unknown", that R11 was unable to report the cause of the injury, used anticoagulants; and also indicated the injury was considered to be "minor." The facility administrator was notified, but the injury was not reported to the state agency.

During an interview about the three injuries of unknown origin on 7/24/15, at 12:54 p.m., the SW stated, R11 "had more bruising than anyone I have ever known." The SW said the bruise on R11's hand "may have been caused by recent trimming of [R11's] nails," indicating R11 caused the bruise herself. Regarding the bruise noted to R11's temple and forehead, the SW stated that nursing felt the bruising "was due to placement of [R11's] nebulizer mask," however, the SW stated, she interviewed R11 who reported that

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she slipped and fell on her way back from supper. SW further stated R11 did not ambulate, used a Hoyer lift [a mechanical lift] for transferring, and there were no records of any falls. SW added the bruising was "likely due to placement of [R11's] nebulizer mask." No further investigation was completed for this injury.

During an interview on 7/24/15, at 12:54 p.m., the DON stated R11 "could reliably answer" when the reporting nurse asked if bruising was related to abuse, therefore, the DON felt the injury was not reportable.

Although R11 was identified to be moderately cognitively impaired, and had multiple bruises at different locations, there was no indepth investigation completed to determine the actual causes of R11's bruises. The facility administrator was notified of the injuries but none of these incidents were submitted to the state agency.

R66's quarterly MDS, dated 1/7/15, indicated she was moderately, cognitively impaired. The CP, dated 2/9/15, indicated R66 required extensive assist of two staff, with use of a mechanical lift, for transfers. The CP also indicated R66 was at risk for delirium and potential abuse, related to depression.

A review of SSIRF dated 2/3/15, indicated during a review of R66's nursing progress note dated 1/26/2015, there was "presence of unknown bruises" on [R66] both arms, the size was identified as bruising "from hands to shoulder." The SSIRF also indicated R66 now wore sleeve/arm protectors. The SSIRF indicated this

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was an "unknown injury", that R66 was unable to state the cause, and that the injury was assessed to be "minor." The injury was reported to the facility administrator, but was not not reported to the state agency.

During an interview on 7/24/15, at 12:54 p.m., the SW stated, the bruises were noted while the DON was reviewing R66's progress notes. The SW said she "spoke with nursing" and determined the bruising was assessed "to be a minor injury, and therefore not reportable to the state agency."During an interview on 7/24/15, at 12:54 p.m., the DON said R66 used a Hoyer lift (mechanical lift), and R66 did not always cooperate in lift, occasionally "flailing her arms." The DON further stated R66 was confused, and that it would be "hard to say if R66 would have been able to to talk about how the bruising occurred after any time had passed."

Although R66 had bilateral bruising from her hands to her shoulders, the injury was unwitnessed and the resident was unable to identify what happened. The facility had not immediately reported the incident to the state agency nor was a thorough investigation completed to determine if R66 was "flailing her arms" while using the mechanical lift.

R44's annual MDS, dated 6/9/15, indicated she was severely cognitively impaired. The CP, dated 7/10/15, indicated R44 required extensive assist with ADLs, and was at risk for abuse, related to short term memory loss and impaired decision-making skills.

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F 226	Continued From page 44	F 226		

A review of SSIRF dated 6/15/15, indicated R44 had a purple bruise on her posterior (back side) forearm, measuring 6.3 cm x 7 cm, that was found during her bath. The SSIRF indicated this was an "unknown" injury, and R66 could not state the cause of injury. The injury was determined to be "minor". The facility administrator was notified, but the injury was not reported to the state agency.

During an interview on 7/24/15, at 12:54 p.m., the SW stated, "The injury was determined by nursing staff to be 'minor' and did not meet any suspicious criteria. The SW said she "did not see a need to report" to the state agency.

In an interview on 7/24/15, at 12:54 p.m., the DON stated, "[R44] would have been able to tell you if something happened, she could make her needs known."

Even though R44 was assessed to be severely cognitively impaired, had an injury of "unknown" origin, on the posterior of her arm. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency.

R8's quarterly minimum data set (MDS) identified her to be severely cognitively impaired and requiring assist of two staff for activities of daily living. CP dated 5/15/15 indicated R8 required extensive assist for activities of daily living and was at risk for abuse related to diagnosis of dementia.

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F 226	Continued From page 45	F 226		

A review of SSIRF dated 8/18/14, indicated R8 had a bruise measuring 8.5cm in length between her thumb and forefinger from the base of her thumb to her wrist. The reporting nurse did the initial evaluation and determined the bruising resulted from R8 wringing her hands, and the wringing of her hands was witnessed by staff.

During an interview on 7/24/15, at 12:54 p.m., SW stated, the injury was not reportable due to staff witness of the potential cause. No further investigation of the injury was completed. The facility administrator was notified of the injury but a report was not made to the state agency. A Social Services Incident Referral form was requested for this injury but was not received.

Although R8 had severe cognitive impairment, and had a bruise 8.5cm between her thumb and forefinger from the base of her thumb to her wrist. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency.

During an interview on 7/24/15, at 12:54 p.m., SW stated, when making a determination of whether or not to report an injury to the state agency, she "refers to statutes, and uses a decision tree." The SW also stated that she looks at whether a resident is able to explain the injury, or if someone else saw it, and if there was a history of other recent falls and/or injuries. The SW further stated, "If the nurses indicated minor injury or injury not suspicious in nature or location, it does not need to be reported."

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F 226	Continued From page 46	F 226		

During an interview on 7/24/15, at 12:54 p.m., the DON said, minor injuries are not reportable to the state agency. She further stated, there was "no criteria or policy" the facility has to identify and determine whether an injury was "minor" versus "major." The DON also stated she "would use the nurses judgement" when determining if an injury was minor or major, and that the RN in charge "followed up on the injuries." However, she stated there was no charting on the clinical record that would show evidence that follow-up had been completed.

REFERENCE CHECKS

The facility's Abuse Prevention Policy, revised 7/15, indicated as its purpose "...to protect adults who are vulnerable to abuse..." Further, the policy included: "To assure the facility was doing everything within its control to prevent the occurrence of abuse or neglect...the facility would attempt to obtain information from previous employers and or/current employers."

NA-A's personnel record identified they were hired on 7/13/15. The personnel record lacked evidence reference checks were completed prior to employment at the facility.

NA-B's personnel record identified they were hired on 6/30/15. The personnel record lacked evidence reference checks were completed prior to employment at the facility.

Dietary Aide (DA)-A's personnel record identified they were hired on 6/23/15. The personnel record lacked evidence reference checks were

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F 226	Continued From page 47 completed prior to employment at the facility. Registered nurse (RN)-B's personnel record identified they were hired on 5/11/15. The personnel record lacked evidence reference checks were completed prior to employment at the facility. On 7/23/15, at 8:45 a.m. human resources (HR) staff stated four of the five newly hired employees did not have documentation of reference checks. HR stated there was "not a process" to document that reference checks had been completed. They facility used the application references "to inquire about the position held, date of hire, eligibility for rehire and any feedback."	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified rising and morning routines for 2 of 8 residents (R50 and R12),who required extensive staff assistance to complete activities of daily living (ADL's). R50's diagnoses, as identified on the care plan (CP), reviewed 6/6/2015, included hemiplegia, dementia, and aphasia. The quarterly Minimum Data Set (MDS), dated 5/27/2015, indicated R50	F 241	F241 Affects R50 &R12. Potential to affect all residents 1. 8/11/15:Dignity & respect & it's relationship to cares was discussed at the nsg staff meeting 8/11/15. 2. 8/14/15: NAR night duty assignment sheet was revised (Attachment L) 3.8/14/15: an email to all NARs regarding dignity & respect and AM cares was sent by the DON & included.	8/14/15

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F 241	Continued From page 48 had severely impaired cognition, required extensive, physical assistance for ADL's, including two-person assist with bed mobility, transfers, toileting, dressing and personal hygiene. During observation on 7/22/2015 at 7:11 a.m., R50 was lying on her back, in her bed, with her left hand positioned on top of her chest. R50's blanket was at the foot of the bed, pulled onto the resident, exposing R50's left leg, and one could see she already had pants on as she lied in bed. R50 remained in bed until 8:41, when NA-F and NA-G assisted her with morning cares. R50 was already dressed, with pants, socks and shirt, when NA-F removed R50's covers and checked for incontinence, NA-F and NA-G assisted R50 into her wheel chair with use of a mechanical lift. NA-F then brushed her hair, and NA-G assisted in placing R50's hand splint and arm into the wheel chair armrest and R50 was up for the day. During an interview on 7/22/2015 at 8:38 a.m., NA-G said R50 was already dressed this morning, and we "just needed to get up, out of bed." NA-G said R50 needed "total assistance" dressing, and R50 was not able to verbalize her needs to staff. In an interview on 7/22/2015 at 9:18 a.m., NA-F acknowledged R50 was dressed this morning when she assisted R50 to get up for the day. NA-F did not know who worked with R50, but said "someone on nights [the night shift] got her dressed," and that was typical for R50's routine. NA-F also said R50 would not be dressed early on Tuesdays, "because she gets a bath on that day."	F 241	"No resident should be gotten up on the noc shift for the convenience of staff. Only Residents who are awake & choose to get up or if they are restless & attempting to get out of bed and or it is written in their care plan that they get up at a specific time". Monitoring 8/24/15- 9/28/15 An audit will be performed every day x1 week, then every week x4 weeks to ensure dignity & respect of all residents with their AM cares. The day nurse/TMA who arrives @0600 will round on their scheduled wing. They will observe and document the residents who are up and or dressed and back in bed. The report will be given to the RN Care Coordinator for review if Dignity & Respect was provided. The Care Coordinator will forward the review form to the DON after their review. (Attachment M) Responsibility: Nurses/TMA, Care Coordinators & DON Audit reports will be reported to the Quality Assurance Committee. (QA meets quarterly; Oct., Jan., April and July).	

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During an interview on 7/24/2015 at 6:00 a.m., NA-H stated she works on the overnight shift, and routinely got R50 "cleaned up and dressed," but not removed from bed, "the day shift would do that." NA-H stated she does not get R50 dressed on her scheduled bath days. She has a list of residents whom she helped get cleaned and dressed, prior to the end of the night shift. NA-H said "I just need to make sure they are dressed and ready to go. I get them dressed and then put them back to bed; it helps out the morning shift." NA-H said if there was a resident that did not want to get up, she was instructed "to get someone else up." NA-H did add that some of the residents she assisted "liked to get up early," and there were some who simply "were up all night anyway."

During an interview on 7/24/2015 at 1:06 p.m., family member (FM)-A said he was unaware staff were getting R50 dressed, then having her stay in bed. FM-A said that depending on the night, R50 was often awake late, or was "up at 3:00 a.m. and restless, and they [staff] will get her up." FM-A than stated, "I would think if [R50] got dressed, she'd be getting out, and up to breakfast for the day."

In an interview on 7/24/2015 at 1:17 p.m., the director of nursing (DON) stated the night shift try "to help the day shift staff." The DON said "If someone was trying to get up, then get them up, and keep [the resident] from getting out of bed and possibly fall." In the same interview, the social worker (SW) said getting a resident up during the night was "not just a decision for the aide. We should look into this some more."

R12's quarterly minimum data set (MDS), dated

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5/18/15, indicated she was severely, cognitively impaired and required extensive assist for transfers, dressing and grooming. The care plan (CP), dated 8/28/13, directed staff to give R12 opportunities to make daily preferences choices, including clothing, bed time and bathing. The CP also indicated R12 had an alteration in sleep, related to insomnia, with a goal of at least six hours of sleep at night. The CP did not address a morning routine preference of when R12 wanted to get up.

During observation on 7/22/15 at 7:00 a.m., R12 was noted fully dressed and seated in her wheel chair. R12 was positioned in front of the television in the common area on the east wing, asleep in her wheelchair. R12 repeatedly made jerking movements as she dozed. R12 remained in chair until 8:15 a.m., (75 minutes) when staff approached, and awakened her. The staff asked R12 if if she wanted to go back to bed, or eat breakfast. R12 replied "I don't care."

During an interview on 7/24/15, at 5:59 a.m., NA-E stated she was instructed to get four residents up, washed and dressed when working the over night shift. NA-E stated if a resident had shower, there was another one assigned to get up in their place. NA-E stated she will usually "get the residents up, washed, dressed and put them back to bed."

During an interview on 7/24/15 12:24 p.m., licensed practical nurse (LPN)-C stated, " usually the over night shift is getting up the early risers, she stated they are not getting up anyone that would normally sleep in. LPN-C further stated, "Some of the Hoyers [residents who require use

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of a mechanical lift to transfer] get washed, dressed and put back in bed, I don't have any idea why they would do that."

During an interview on 7/24/15, at 1:16 p.m., the director of nursing (DON) stated, there are many people getting up and dressed and put back to bed on the night shift. She stated, The nurses and care coordinators schedule them to help the day shift. The DON further stated, "the people on this list are usually up or crawling out of bed," we like the night shift to help day shift "get a jump on the day." She further stated, "I'm sure we are not the only nursing home in the world that does that." The intent is to help day shift out and prevent falls. The DON stated she was not sure if the rationale for waking a resident on night shift to get them washed and dressed is on the care plan or not.

During an interview on 7/24/15, at 2:07 p.m., registered nurse (RN)-C stated, We schedule residents for the night shift to get up, washed and dressed. She stated, We usually look at people who are trying to get up but if there aren't enough people who want to get up, we will pick people who are a "Hoyer lift." The aides will wash and dress them in bed. RN- C stated, "If someone prefers to get up early it is not care planned." She further stated, there is no one currently on the East unit that is care planned to get up early due to fall risk. RN-C stated, The rationale for night shift getting resident's washed and dressed is due to the workload in the morning.

Review of the facility's undated East night group sheet directed night shift to complete morning cares, oral cares, dressing, making bed and cleaning up room for five residents on the unit,

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F 241	Continued From page 52 including R12. A review of the facility policy, Rights and Responsibilities of Patients/Residents, dated 4/15, indicated the facility "must, with courtesy, promote care for [residents] in a manner that maintains and enhances dignity and respect in full recognition of [a resident's] individuality."	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care for timely repositioning and toileting assistance for 1 of 1 residents (R50) with urinary incontinence, and at risk for pressure ulcer development. Findings include: R50's diagnoses, as identified on the care plan (CP), reviewed 6/6/2015, included hemiplegia affecting dominant side, dementia, and aphasia due to cerebrovascular disease. The quarterly Minimum Data Set (MDS), dated 5/27/2015, indicated R50 had severely impaired cognition, and was unable to walk. The MDS also identified R50 required extensive, physical assistance for activities of daily living (ADLs), including two-person assist with bed mobility, transfers,	F 282	F282: Affects R50 with the Potential to Affect All Residents requiring repositioning and toileting. 1. On 7/23/15: an email was sent to all LTC staff, including Activity staff, by the Care Coordinator. indicating the following: "Make sure resident's are being toileted and repositioned @ minimum of every 2 hrs. or more frequently if noted in the care plan. 2. A toileting/reposition/skin worksheet (Attachment N) will be placed in the NAR three ring binder @ each nurses' station. Staff will document each time that they assist the resident with repositioning and or toileting. Monitoring An audit of the toileting/repositioning/skin	8/20/15

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F 282	Continued From page 53 toileting, and personal hygiene. R50's care plan (CP) identified the potential for alteration in skin integrity, and also R50's alteration in elimination/toileting. The CP directed staff to follow the mobility plan of care, and assist R50 "to turn and reposition every 2 hours and PRN" [as needed]. Additionally, the CP directed staff to assist R50 "to check and change every 2 hours and PRN" [as needed]. During continuous observation on 7/23/2015 from 7:55 a.m. to 11:12 a.m. (3 hours and 7 minutes) R50 was observed to be dressed and seated upright in her wheel chair. At 7:55 a.m., R50 was seated in her wheel chair in the living area across from the north unit nursing station and watching a news program on TV. At 8:33 a.m., R50 was wheeled into the dining room and assisted with breakfast, finishing at 9:36 a.m. Following the meal, and still seated in the wheel chair, R50 was moved from the table where food was served to the activity area in the same room. R50 participated in the morning activity, and stayed in the activity area until just after 10:00 a.m., when a staff member wheeled her into the main entryway of the facility. R50 remained there, still seated in her wheel chair, until 10:19 a.m., when a staff member pushed R50 outside of the building, joining other residents to get fresh air. At 10:37 a.m., R50 was returned into the building near the aviary, and was approached by nursing assistant (NA)-F, who after greeting R50, took her vital signs. More than 2 1/2 hours had elapsed since R50 was last toileted or repositioned. R50 remained seated in her wheel chair near the aviary until 11:12 a.m., when NA-F assisted her back to her room. In her room, NA-F and registered nurse (RN)-B, using the mechanical	F 282	worksheet will be completed by nursing 1x/shift for 1 week then weekly x4 weeks (8/26/15-9/30/15) (Attachment O) Responsibility: DON, Care Coordinators, Nursing Staff. Audit reports will be reported to the Quality Assurance Committee. (QA meets quarterly; Oct., Jan., April and July).	

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F 282	Continued From page 54 lift, assisted R50 into her bed. R50 was incontinent of urine, and NA-F provided perineal care. RN-B assessed R50's skin, which was pink in color, free of any unusual warmth or swelling, there were no reddened areas, and her skin was fully intact. RN-B also said R50 was incontinent of urine. R50 was not toileted or repositioned from 7:55 a.m. to 11:12 a.m., a total of 3 hours and 7 minutes. During an interview on 7/23/2015 at 11:16 a.m., nursing assistant (NA)-F stated R50 was last repositioned when she was put in her wheel chair "at about quarter to eight." NA-F then stated R50 was on an "every two hour repo [repositioning] schedule," and that R50 should also be checked for "urinary incontinence." NA-F said R50 "Was definitely ready to be repositioned." In an interview on 7/23/2015 at 4:00 p.m. registered nurse (RN)-A said she "trusted the work group on the floor to get toileting and repositioning completed," but what happened today, "I'll say was a fluke." RN-A also stated, "I'll be honest, [R50] should have been turned." During an interview on 7/27/2015 at 1:19 p.m., the director of nursing (DON) said resident interventions were care planned, and the facility takes "very seriously, residents' needs for timely assistance." A facility policy regarding the implementation of care plans was requested, but none provided.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314		8/20/15

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F 314	Continued From page 55 resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning for 1 of 2 residents (R50) reviewed in the sample identified at risk for development of pressure ulcers. Findings include: R50's diagnoses, as identified on the care plan (CP), reviewed 6/6/2015, included hemiplegia affecting dominant side, dementia, and aphasia due to cerebrovascular disease. The quarterly Minimum Data Set (MDS), dated 5/27/2015, indicated R50 had severely impaired cognition, and was unable to walk. The MDS also identified R50 required extensive, physical assistance for activities of daily living (ADLs), including two-person assist with bed mobility, transfers, toileting, and personal hygiene. A Braden Pressure Sore Risk Assessment, dated 5/26/2015, indicated R50 was at moderate risk for development of pressure sores. A comprehensive skin assessment summary, dated 5/26/2015, identified R50 required extensive to total assist with ADLs, that she was unable to walk, and was on a turn-and-reposition schedule every 2 hours. The care area assessment (CAA)	F 314	F314 affects R50 and has the potential to affect all residents requiring physical assistance with ADL's and are at a risk for developing pressure ulcers. 1. On 7/23/15: an email was sent to all LTC staff, including Activity staff, by the Care Coordinator. indicating the following: "Make sure resident's are being toileted and repositioned @ minimum of every 2 hrs. or more frequently if noted in the care plan. 2. A toileting/reposition/skin worksheet (Attachment N) will be placed in the NAR three ring binder @ each nurses' station. Staff will document each time that they assist the resident with repositioning and or toileting. Monitoring An audit of the toileting/repositioning/skin worksheet will be completed by nursing 1x/shift for 1 week then weekly x4 weeks (8/26/15-9/30/15) (Attachment O) Responsibility: DON, Care Coordinators,	

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	245127	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

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F 314	Continued From page 56 for pressure ulcers, dated 2/25/2015, identified additional pressure ulcer risk factors for R50 including immobility, incontinence, cognitive loss and functional limitation in range of motion. R50's CP identified the potential for alteration in skin integrity. The CP directed staff to follow the mobility plan of care, and assist R50 "to turn and reposition every 2 hours and PRN" [as needed]. The nursing assistant care sheet "North" unit, undated, directed for R50: T & R q 2 hrs [turn and reposition every 2 hours]. During continuous observation on 7/23/2015 from 7:55 a.m. to 11:12 a.m. (3 hours and 7 minutes) R50 was observed to be dressed and seated upright in her wheel chair, with her right hand and wrist fitted with a splint device, and her right arm was supported and strapped into the arm rest. At 7:55 a.m., R50 was seated in her wheel chair in the living area across from the north unit nursing station and watching a news program on TV. At 8:33 a.m., R50 was wheeled into the dining room and assisted with breakfast, finishing at 9:36 a.m. Following the meal, and still seated in the wheel chair, R50 was moved from the table where food was served to the activity area in the same room. R50 participated in the morning activity, and stayed in the activity area until just after 10 a.m., when a staff member wheeled her into the main entryway of the facility. R50 remained there, still seated in her wheel chair, until 10:19 a.m., when a staff member pushed R50 outside of the building, joining other residents to get fresh air. At 10:37 a.m., R50 was returned into the building near the aviary, and approached by nursing assistant (NA)-F, who after greeting R50, took her vital signs. More than 2 1/2 hours had elapsed since the initial observation, and still R50	F 314	Nursing Staff. Audit reports will be reported to the Quality Assurance Committee. (QA meets quarterly; Oct., Jan., April and July).	

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F 314	Continued From page 57	F 314		

was not off loaded, or repositioned out of her wheel chair. R50 remained seated in her wheel chair near the aviary until 11:12 a.m., when NA-F assisted her back to her room. In her room, NA-F and registered nurse (RN)-B, using the mechanical lift, assisted R50 into her bed. R50 was incontinent of urine, and NA-F provided cleansing cares for her. In the presence of the surveyor, RN-B inspected and assessed R50's skin. R50's skin was normal pink in color, free of any unusual warmth or swelling, there were no reddened areas, and her skin was fully intact. RN-B also said R50 was incontinent of urine. R50 had not been repositioned from 7:55 a.m. to 11:12 a.m., a total of 3 hours and 7 minutes.

During an interview on 7/23/2015 at 11:16 a.m., nursing assistant (NA)-F stated R50 was last repositioned when she was put in her wheel chair "at about quarter to eight." NA-F then stated R50 was on an "every two hour repo [repositioning] schedule," and R50, "Was definitely ready to be repositioned."

A review of nursing and physician long-term care progress notes from 3/26/2015 to 7/14/2015, indicated R50 did not have, nor was being treated for a current pressure ulcer. During this time, R50 did not develop a pressure ulcer.

In an interview on 7/23/2015 at 4:00 p.m. registered nurse (RN)-A stated she would consider any resident "who had a stroke to be at risk for pressure sores." RN-A also said she would "look at everything" to determine if a resident was at risk to develop a pressure ulcer. RN stated R50 scored "a 13 on the Braden" (a measure for predicting pressure ulcer risk), but that also R50 "had immobility, incontinence, and

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F 314	Continued From page 58 other risk factors" and was "at risk for pressure." RN-A said she trusted the work group on the floor to get toileting and repositioning completed, but what happened today, "I'll say was a fluke." RN-A also stated, "I'll be honest, she should have been turned." During an interview on 7/27/2015 at 1:19 p.m., the director of nursing (DON) said the nurse manager had already taken steps to avoid issues when a resident is on a schedule to be turned and checked for incontinence. The DON said in this instance, "[R50] should not go right from breakfast into other activities, that is too long." The DON said resident interventions were care planned, and the facility takes "very seriously, residents' needs for timely assistance." A facility policy, Treatment and Prevention of Skin Breakdown and Ulcers, reviewed 3/14, indicated "It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity..." and "implement preventive measures..." Further, the policy directed, to "establish and record an individualized turning and repositioning schedule if the resident is immobile."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	F 315		8/20/15

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F 315	Continued From page 59 infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely toileting assistance for 1 or 1 residents (R50) who had urinary incontinence. Findings include: R50's diagnoses, as identified on the care plan (CP), reviewed 6/6/2015, included hemiplegia affecting dominant side, dementia, and aphasia due to cerebrovascular disease. The quarterly Minimum Data Set (MDS), dated 5/27/2015, indicated R50 had severely impaired cognition, and was unable to walk. The MDS also identified R50 required extensive, physical assistance for activities of daily living (ADLs), including two-person assist with bed mobility, transfers, toileting, and personal hygiene. A bowel and bladder assessment, dated 2/25/2015, indicated R50 was incontinent of bowel and bladder, and also was not safe to use a commode or toilet due to poor trunk control. Further, the assessment indicated R50 would "be checked for incontinence q 2hr [every 2 hours] and peri care given after each incontinence episode." The care area assessment (CAA) for urinary incontinence, dated 3/11/2015, indicated R50 had dementia, and past history of cardio-vascular accident (stroke), with right-sided hemiplegia. The CAA also indicated R50 was not a candidate for retraining. R50's CP identified alteration in elimination/toileting, that she was incontinent of	F 315	315: Affects R50 with the Potential to Affect All Residents who have urinary incontinence & require assistance with toileting 1. On 7/23/15: an email was sent to all LTC staff, including Activity staff, by the Care Coordinator. indicating the following: "Make sure resident's are being toileted and repositioned @ minimum of every 2 hrs. or more frequently if noted in the care plan. 2. A toileting/reposition/skin worksheet (Attachment N) will be placed in the NAR three ring binder @ each nurses' station. Staff will document each time that they assist the resident with repositioning and or toileting. Monitoring An audit of the toileting/repositioning/skin worksheet will be completed by nursing 1x/shift for 1 week then weekly x4 weeks (8/26/15-9/30/15) (Attachment O) Responsibility: DON, Care Coordinators, Nursing Staff. Audit reports will be reported to the Quality Assurance Committee. (QA meets quarterly; Oct., Jan., April and July).	

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F 315	Continued From page 60	F 315		

bowel and bladder, and also that R50 was not using the bathroom due to safety. The CP directed staff to assist R50 "to check and change every 2 hours and PRN" [as needed]. The nursing assistant care sheet "North" unit, undated, also directed for R50: Check and change q 2hrs and PRN [every 2 hours and as needed].

During continuous observation on 7/23/2015 from 7:55 a.m. to 11:12 a.m. (3 hours and 7 minutes) R50 was observed to be dressed and seated upright in her wheel chair, with her right hand and wrist fitted with a splint device, and her right arm was supported and strapped into the arm rest. At 7:55 a.m., R50 was seated in her wheel chair in the living area across from the north unit nursing station and watching a news program on TV. At 8:33 a.m., R50 was wheeled into the dining room and assisted with breakfast, finishing at 9:36 a.m. Following the meal, and still seated in the wheel chair, R50 was moved from the table where food was served to the activity area in the same room. R50 participated in the morning activity, and stayed in the activity area until just after 10 a.m., when a staff member wheeled her into the main entryway of the facility. R50 remained there, still seated in her wheel chair, until 10:19 a.m., when a staff member pushed R50 outside of the building, joining other residents to get fresh air. At 10:37 a.m., R50 was returned into the building near the aviary, and approached by nursing assistant (NA)-F, who after greeting R50, took her vital signs. More than 2 1/2 hours had elapsed since the initial observation, and still R50 was not off loaded, or repositioned out of her wheel chair. R50 remained seated in her wheel chair near the aviary until 11:12 a.m., when NA-F assisted her back to her room. In her room,

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F 315	Continued From page 61	F 315		

NA-F and registered nurse (RN)-B, using the mechanical lift, assisted R50 into her bed. R50 was incontinent of urine, and NA-F provided cleansing cares for her. In the presence of the surveyor, RN-B inspected and assessed R50's skin, and also said R50 was incontinent of urine. R50 was not assisted for toileting from 7:55 a.m. to 11:12 a.m., a total of 3 hours and 7 minutes.

During an interview on 7/23/2015 at 11:16 a.m., nursing assistant (NA)-F stated R50 was last repositioned when she was put in her wheel chair "at about quarter to eight." NA-F then stated R50 was on an "every two hour repo [repositioning] schedule," and that R50 should also be checked for "urinary incontinence."

In an interview on 7/23/2015 at 4:00 p.m. registered nurse (RN)-A stated she would consider resident "who had a stroke to be at risk for pressure sores." RN stated R50 scored "a 13 on the Braden" (a measure for predicting pressure ulcer risk), but that also R50 "had immobility, incontinence, and other risk factors" and was "at risk for pressure." RN-A said she trusted the work group on the floor to get toileting be completed, but what happened today, "I'll say was a fluke."

During an interview on 7/27/2015 at 1:19 p.m., the director of nursing (DON) said the nurse manager had already taken steps to avoid issues when a resident is on a schedule to be turned and checked for incontinence. The DON said in this instance, "[R50] should not go right from breakfast into other activities, that is too long." The DON said resident interventions were care planned, and the facility takes "very seriously, residents' needs for timely assistance."

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F 315	Continued From page 62 A facility policy, Bowel and bladder Program Policy, revised 3/14, indicated as its purpose to "Maintain resident's optimal bowel and bladder continence and maintain skin integrity The policy indicated individual care plan will address "Times to toilet based on individual schedule and/or checking for incontinence."	F 315		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure exhaust fan duct work, lights above grill and screen in the kitchen were clean of dust and debris. This had potential to affect all residents, staff and visitors who consumed food from the kitchen. Findings include: During the initial tour of the facility kitchen with registered dietician (RD) on 7/20/15, at 1:15 p.m.; six metal caged lights above the grill where the food is cooked, were covered with 1/4 inch visible thick dust and debris from the light fixtures. In addition there was a 12 inch long by 6 inch window screen above the kitchen sink which was completely covered in a black dust and debris. An additional tour was completed on 7/21/15, at	F 465	Potential to Affect All Residents, Staff, and Visitors who consume food from the Kitchen 1. Small window was cleaned on 7/21/15 2. Light in hood system was cleaned on 7/21/15 3. Nutrition Services staff was notified of POC at department meeting on 8/18/15 4. Cleaning of hood box will occur monthly. 5. Cleaning of small window will occur monthly. 6. Cleaning procedure for hood box was developed. (Attachment P) Nutrition services staff will be in-serviced on this cleaning procedure at the	8/18/15

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F 465	Continued From page 63 7:30 a.m. the lights and screen were still observed to be covered with visible dust and debris. During interview 7/21/15, at 8:15 a.m. dietary manager (DM) stated the lights were covered in dust along with the screen; the maintenance department was in charge of cleaning these items. The DM stated the maintenance has a staff of 5 and 3 of them are on light duty so things just are not getting done. During interview 7/21/15, at 8:30 a.m. the maintenance manager (MM)-A stated they have a contracted service that cleans the overhead hood vent two times a year. The maintenance director did inspect the lights and the screen and stated "That doesn't cut it" and expressed it is still the expectation to complete needed tasks. Review of the facility contracted cleaning service document form Fire Protection Equipment Co. After Service Follow Up Report dated 9/22/14, indicated the kitchen exhaust system hood was cleaned but not to code due to them being inaccessible. The recommendations indicated to "replacing box-style fan with upblast style to better access duct work." The company was out again on 3/2/15 and the Fire Protection Equipment Co. After Service Follow Up Report recommended "replacing box-style down blast fan with upblast fan to access fan and duct work. Replace damaged filters." During interview 7/22/15, at 2:00 p.m. the MM-A stated the "fan blows down and then diverts the air up to create a vacuum up and out of the roof". The MM-A stated the fans should be cleaned, but that is how this style exhaust fan works and it is	F 465	Department Meeting help on 8/18/15 Monitoring Nutrition Services Manager will conduct an audit on the 4th Monday starting in Aug. & for next six months to ensure this system is being followed and is adequate for keeping the equipment clean. (Attachment Q) Responsibility: Dietary Manager Audit reports will be reported to the Quality Assurance Committee. (QA meets quarterly; Oct., Jan., April and July).	

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F 465	Continued From page 64 grandfathered until we remodel the kitchen at some uncertain time. During phone interview 7/22/15, at 2:15 p.m. with representative from the Fire Protection Equipment Co. stated the fan and ducts are inaccessible because they were unable to see down to the bare metal. The system was very old, which was probably manufactured in 1960's or 70's, and recommended a new unit. The facilities Nutritional Services Cleaning Procedure Equipment Hood policy undated indicated 1. the inside and outside of the hood will be cleaned once per month 2. clean the inside and outside of the hood 3. clean the light fixtures within the hood. Remove the light fixtures and clean with soap 4. use a brush or cloth as needed to remove grease and/or dust 5. wash hood with soap and water 7. the interior section of the hood that extends to the roof is cleansed semi annually by a commercial hood-cleaning operator.	F 465		

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	245127	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/22/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Mille Lacs Health System C & NC was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Mille Lacs Health Center is a 1-story building with no basement. The original building was constructed in 1961 with an addition constructed in 1971. The 1961 building is of type II(111) construction and the 1971 building is type II(111) construction. Therefore, the nursing home was inspected as one building. From 2002-2004 the facility under went a complete renovation. A hospital, properly separated, is connected to the nursing home. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 57 beds and had a census of 50 at the time of the survey. The requirement at 42 CFR Subpart 483.70 is MET.	K 000		

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

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
September 4, 2015

Ms. Kim Kucera, Administrator
Mille Lacs Health System
200 North Elm Street
Onamia, Minnesota 56359

****This letter redacts and replaces the letter dated August 10, 2015.****

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5127025

Dear Ms. Kucera:

The above facility was surveyed on July 20, 2015 through July 27, 2015 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 one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule 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 me.

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,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00374	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

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

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2 000	Continued From page 1 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. On July 20-24 and July 27th, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by:	2 302		8/18/15

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2 302	Continued From page 3 Based on interview and document review, the facility failed to ensure consumers were provided information regarding Alzheimer's disease and dementia training, including a description of the training program, the categories of employees trained, the frequency of training and the basic topics covered in the training in a written or electronic form. This had the potential to affect all residents and their families. Findings include: During a review of the facility's Alzheimer's training program, there was no information or documentation that indicated the consumers (resident families) were provided a description of Alzheimer's training program, categories of employees trained, frequency of training and the basic topics covered. During an interview on 7/21/15, at 4:07 p.m., the social worker stated, dementia training was completed through educare. She stated she not sure how resident families received this information. The director of nursing (DON) stated, no family education was provided regarding Alzheimers' training, and she was unaware that it was required. SUGGESTED METHOD OF CORRECTION: The DON or designee could add information regarding staff training to the resident admission packet so consumers were aware of this information. The DON or designee could educate staff about this requirement and conduct audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302	Corrected 8/18/15	

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2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care for timely repositioning and toileting assistance for 1 of 1 residents (R50) with urinary incontinence, and at risk for pressure ulcer development. Findings include: R50's diagnoses, as identified on the care plan (CP), reviewed 6/6/2015, included hemiplegia affecting dominant side, dementia, and aphasia due to cerebrovascular disease. The quarterly Minimum Data Set (MDS), dated 5/27/2015, indicated R50 had severely impaired cognition, and was unable to walk. The MDS also identified R50 required extensive, physical assistance for activities of daily living (ADLs), including two-person assist with bed mobility, transfers, toileting, and personal hygiene. R50's care plan (CP) identified the potential for alteration in skin integrity, and also R50's alteration in elimination/toileting. The CP directed staff to follow the mobility plan of care, and assist R50 "to turn and reposition every 2 hours and PRN" [as needed]. Additionally, the CP directed staff to assist R50 "to check and change every 2	2 565	corrected 8/20/15	8/20/15

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2 565	Continued From page 5 hours and PRN" [as needed]. During continuous observation on 7/23/2015 from 7:55 a.m. to 11:12 a.m. (3 hours and 7 minutes) R50 was observed to be dressed and seated upright in her wheel chair. At 7:55 a.m., R50 was seated in her wheel chair in the living area across from the north unit nursing station and watching a news program on TV. At 8:33 a.m., R50 was wheeled into the dining room and assisted with breakfast, finishing at 9:36 a.m. Following the meal, and still seated in the wheel chair, R50 was moved from the table where food was served to the activity area in the same room. R50 participated in the morning activity, and stayed in the activity area until just after 10:00 a.m., when a staff member wheeled her into the main entryway of the facility. R50 remained there, still seated in her wheel chair, until 10:19 a.m., when a staff member pushed R50 outside of the building, joining other residents to get fresh air. At 10:37 a.m., R50 was returned into the building near the aviary, and was approached by nursing assistant (NA)-F, who after greeting R50, took her vital signs. More than 2 1/2 hours had elapsed since R50 was last toileted or repositioned. R50 remained seated in her wheel chair near the aviary until 11:12 a.m., when NA-F assisted her back to her room. In her room, NA-F and registered nurse (RN)-B, using the mechanical lift, assisted R50 into her bed. R50 was incontinent of urine, and NA-F provided perineal care. RN-B assessed R50's skin, which was pink in color, free of any unusual warmth or swelling, there were no reddened areas, and her skin was fully intact. RN-B also said R50 was incontinent of urine. R50 was not toileted or repositioned from 7:55 a.m. to 11:12 a.m., a total of 3 hours and 7 minutes.	2 565		

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2 565	Continued From page 6 During an interview on 7/23/2015 at 11:16 a.m., nursing assistant (NA)-F stated R50 was last repositioned when she was put in her wheel chair "at about quarter to eight." NA-F then stated R50 was on an "every two hour repo [repositioning] schedule," and that R50 should also be checked for "urinary incontinence." NA-F said R50 "Was definitely ready to be repositioned." In an interview on 7/23/2015 at 4:00 p.m. registered nurse (RN)-A said she "trusted the work group on the floor to get toileting and repositioning completed," but what happened today, "I'll say was a fluke." RN-A also stated, "I'll be honest, [R50] should have been turned." During an interview on 7/27/2015 at 1:19 p.m., the director of nursing (DON) said resident interventions were care planned, and the facility takes "very seriously, residents' needs for timely assistance." A facility policy regarding the implementation of care plans was requested, but none provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and / or designee could review the importance of implementing all residents' plan of cares, to assure resident needs are being met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position	2 905		8/20/15

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2 905	Continued From page 7 must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning for 1 of 2 residents (R50) reviewed in the sample identified at risk for development of pressure ulcers. Findings include: R50's diagnoses, as identified on the care plan (CP), reviewed 6/6/2015, included hemiplegia affecting dominant side, dementia, and aphasia due to cerebrovascular disease. The quarterly Minimum Data Set (MDS), dated 5/27/2015, indicated R50 had severely impaired cognition, and was unable to walk. The MDS also identified R50 required extensive, physical assistance for activities of daily living (ADLs), including two-person assist with bed mobility, transfers, toileting, and personal hygiene. A Braden Pressure Sore Risk Assessment, dated 5/26/2015, indicated R50 was at moderate risk for development of pressure sores. A comprehensive skin assessment summary, dated 5/26/2015, identified R50 required extensive to total assist with ADLs, that she was unable to walk, and was on a turn-and-reposition schedule every 2 hours. The care area assessment (CAA) for pressure ulcers, dated 2/25/2015, identified additional pressure ulcer risk factors for R50 including immobility, incontinence, cognitive loss	2 905	corrected 8/20/15	

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2 905	Continued From page 8	2 905		

and functional limitation in range of motion.

R50's CP identified the potential for alteration in skin integrity. The CP directed staff to follow the mobility plan of care, and assist R50 "to turn and reposition every 2 hours and PRN" [as needed]. The nursing assistant care sheet "North" unit, undated, directed for R50: T & R q 2 hrs [turn and reposition every 2 hours].

During continuous observation on 7/23/2015 from 7:55 a.m. to 11:12 a.m. (3 hours and 7 minutes) R50 was observed to be dressed and seated upright in her wheel chair, with her right hand and wrist fitted with a splint device, and her right arm was supported and strapped into the arm rest. At 7:55 a.m., R50 was seated in her wheel chair in the living area across from the north unit nursing station and watching a news program on TV. At 8:33 a.m., R50 was wheeled into the dining room and assisted with breakfast, finishing at 9:36 a.m. Following the meal, and still seated in the wheel chair, R50 was moved from the table where food was served to the activity area in the same room. R50 participated in the morning activity, and stayed in the activity area until just after 10 a.m., when a staff member wheeled her into the main entryway of the facility. R50 remained there, still seated in her wheel chair, until 10:19 a.m., when a staff member pushed R50 outside of the building, joining other residents to get fresh air. At 10:37 a.m., R50 was returned into the building near the aviary, and approached by nursing assistant (NA)-F, who after greeting R50, took her vital signs. More than 2 1/2 hours had elapsed since the initial observation, and still R50 was not off loaded, or repositioned out of her wheel chair. R50 remained seated in her wheel chair near the aviary until 11:12 a.m., when NA-F assisted her back to her room. In her room,

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2 905	Continued From page 9	2 905		

NA-F and registered nurse (RN)-B, using the mechanical lift, assisted R50 into her bed. R50 was incontinent of urine, and NA-F provided cleansing cares for her. In the presence of the surveyor, RN-B inspected and assessed R50's skin. R50's skin was normal pink in color, free of any unusual warmth or swelling, there were no reddened areas, and her skin was fully intact. RN-B also said R50 was incontinent of urine. R50 had not been repositioned from 7:55 a.m. to 11:12 a.m., a total of 3 hours and 7 minutes.

During an interview on 7/23/2015 at 11:16 a.m., nursing assistant (NA)-F stated R50 was last repositioned when she was put in her wheel chair "at about quarter to eight." NA-F then stated R50 was on an "every two hour repo [repositioning] schedule," and R50, "Was definitely ready to be repositioned."

A review of nursing and physician long-term care progress notes from 3/26/2015 to 7/14/2015, indicated R50 did not have, nor was being treated for a current pressure ulcer. During this time, R50 did not develop a pressure ulcer.

In an interview on 7/23/2015 at 4:00 p.m. registered nurse (RN)-A stated she would consider any resident "who had a stroke to be at risk for pressure sores." RN-A also said she would "look at everything" to determine if a resident was at risk to develop a pressure ulcer. RN stated R50 scored "a 13 on the Braden" (a measure for predicting pressure ulcer risk), but that also R50 "had immobility, incontinence, and other risk factors" and was "at risk for pressure." RN-A said she trusted the work group on the floor to get toileting and repositioning completed, but what happened today, "I'll say was a fluke." RN-A also stated, "I'll be honest, she should have been

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2 905	Continued From page 10 turned." During an interview on 7/27/2015 at 1:19 p.m., the director of nursing (DON) said the nurse manager had already taken steps to avoid issues when a resident is on a schedule to be turned and checked for incontinence. The DON said in this instance, "[R50] should not go right from breakfast into other activities, that is too long." The DON said resident interventions were care planned, and the facility takes "very seriously, residents' needs for timely assistance." A facility policy, Treatment and Prevention of Skin Breakdown and Ulcers, reviewed 3/14, indicated "It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity..." and "implement preventive measures..." Further, the policy directed, to "establish and record an individualized turning and repositioning schedule if the resident is immobile." SUGGESTED METHOD OF CORRECTION: The Director of Nursing and / designee could review with care staff residents requiring repositioning for pressure ulcer preventing and healing, and monitor for compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 905		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the	2 910		8/20/15

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2 910	Continued From page 11 unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely toileting assistance for 1 or 1 residents (R50) who had urinary incontinence. Findings include: R50's diagnoses, as identified on the care plan (CP), reviewed 6/6/2015, included hemiplegia affecting dominant side, dementia, and aphasia due to cerebrovascular disease. The quarterly Minimum Data Set (MDS), dated 5/27/2015, indicated R50 had severely impaired cognition, and was unable to walk. The MDS also identified R50 required extensive, physical assistance for activities of daily living (ADLs), including two-person assist with bed mobility, transfers, toileting, and personal hygiene. A bowel and bladder assessment, dated 2/25/2015, indicated R50 was incontinent of bowel and bladder, and also was not safe to use a commode or toilet due to poor trunk control. Further, the assessment indicated R50 would "be checked for incontinence	2 910	corrected 8/20/15	

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2 910	Continued From page 12 q 2hr [every 2 hours] and peri care given after each incontinence episode." The care area assessment (CAA) for urinary incontinence, dated 3/11/2015, indicated R50 had dementia, and past history of cardio-vascular accident (stroke), with right-sided hemiplegia. The CAA also indicated R50 was not a candidate for retraining. R50's CP identified alteration in elimination/toileting, that she was incontinent of bowel and bladder, and also that R50 was not using the bathroom due to safety. The CP directed staff to assist R50 "to check and change every 2 hours and PRN" [as needed]. The nursing assistant care sheet "North" unit, undated, also directed for R50: Check and change q 2hrs and PRN [every 2 hours and as needed]. During continuous observation on 7/23/2015 from 7:55 a.m. to 11:12 a.m. (3 hours and 7 minutes) R50 was observed to be dressed and seated upright in her wheel chair, with her right hand and wrist fitted with a splint device, and her right arm was supported and strapped into the arm rest. At 7:55 a.m., R50 was seated in her wheel chair in the living area across from the north unit nursing station and watching a news program on TV. At 8:33 a.m., R50 was wheeled into the dining room and assisted with breakfast, finishing at 9:36 a.m. Following the meal, and still seated in the wheel chair, R50 was moved from the table where food was served to the activity area in the same room. R50 participated in the morning activity, and stayed in the activity area until just after 10 a.m., when a staff member wheeled her into the main entryway of the facility. R50 remained there, still seated in her wheel chair, until 10:19 a.m., when a staff member pushed R50 outside of the building, joining other residents to get fresh air.	2 910		

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	00374	A. BUILDING: _____ B. WING _____	07/23/2015

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2 910	Continued From page 13 At 10:37 a.m., R50 was returned into the building near the aviary, and approached by nursing assistant (NA)-F, who after greeting R50, took her vital signs. More than 2 1/2 hours had elapsed since the initial observation, and still R50 was not off loaded, or repositioned out of her wheel chair. R50 remained seated in her wheel chair near the aviary until 11:12 a.m., when NA-F assisted her back to her room. In her room, NA-F and registered nurse (RN)-B, using the mechanical lift, assisted R50 into her bed. R50 was incontinent of urine, and NA-F provided cleansing cares for her. In the presence of the surveyor, RN-B inspected and assessed R50's skin, and also said R50 was incontinent of urine. R50 was not assisted for toileting from 7:55 a.m. to 11:12 a.m., a total of 3 hours and 7 minutes. During an interview on 7/23/2015 at 11:16 a.m., nursing assistant (NA)-F stated R50 was last repositioned when she was put in her wheel chair "at about quarter to eight." NA-F then stated R50 was on an "every two hour repo [repositioning] schedule," and that R50 should also be checked for "urinary incontinence." In an interview on 7/23/2015 at 4:00 p.m. registered nurse (RN)-A stated she would consider resident "who had a stroke to be at risk for pressure sores." RN stated R50 scored "a 13 on the Braden" (a measure for predicting pressure ulcer risk), but that also R50 "had immobility, incontinence, and other risk factors" and was "at risk for pressure." RN-A said she trusted the work group on the floor to get toileting be completed, but what happened today, "I'll say was a fluke." During an interview on 7/27/2015 at 1:19 p.m., the director of nursing (DON) said the nurse	2 910		

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2 910	Continued From page 14 manager had already taken steps to avoid issues when a resident is on a schedule to be turned and checked for incontinence. The DON said in this instance, "[R50] should not go right from breakfast into other activities, that is too long." The DON said resident interventions were care planned, and the facility takes "very seriously, residents' needs for timely assistance." A facility policy, Bowel and bladder Program Policy, revised 3/14, indicated as its purpose to "Maintain resident's optimal bowel and bladder continence and maintain skin integrity The policy indicated individual care plan will address "Times to toilet based on individual schedule and/or checking for incontinence." SUGGESTED METHOD OF CORRECTION: The Director of Nursing and / designee could review with care staff residents requiring assistance with toileting, and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by:	21565		8/13/15

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21565	Continued From page 15 Based on observation, interview and document review, the facility failed to ensure safe self-administration of medications (SAM) for 1 of 1 residents (R63) observed for self-administration of a nebulizer treatment. Findings include: During observation on 7/20/15, at 7:28 p.m. R63 was observed alone in her room with a nebulizer (a drug delivery device used to administer medications in the form of a mist inhaled into the lungs) running, with a face mask. The trained medication aide (TMA)-A who had administered the medicaiton was on the opposite side of the dining room passing medications and assisting other residents in their rooms. R63 remove the mask off her nose and mouth and placed the mask on her chest with the elastic strap still around the back of her neck. The TMA-A walked past R63's room while R63 had the mask on her chest and into the room next to R63 twice. TMA-A made no attempted to check, or reapply the mask to R63's nose and mouth for installation of the medication. At 7:44 p.m. TMA-A entered R63's room turned off the nebulizer and removed the mask from R63's chest. R63's diagnoses included dementia with behavioral disturbances, depression, anxiety, chronic obstructive pulmonary disease (COPD) and congestive heart failure. A cognition care plan dated 6/2/15, indicated R63 was disorientated to time and place and had moderately impaired cognition. The Physician's Orders and the Medication Administration Record (MAR) for 7/15, directed Duoneb to be administered four times a day. A hand written note on the MAR indicated R63 did	21565	corrected 8/13/15	

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21565	Continued From page 16 not like the nebulizer mask and to hold the mask in front of her face and let her breathe in that way. A Self Administration of Medication Assessment effective 7/21/15, indicated R63 was not cognitively able to participate in a SAM. During interview on 7/20/15, at 7:50 p.m. TMA-A stated she did not know if R63 could be left alone with the nebulizer. She usually does not leave residents alone with their nebulizer but because it had been so hectic and busy she left R63 alone. On 7/23/15, at 11:20 a.m. registered nurse (RN)-A stated R63 was assessed to not to be left alone to SAM the nebulizer. In the past she would not even allow the mask but now will allow staff to hold the mask in front of her. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and/or designee could review the facility's policy for assessment of residents for the ability for self administration of medications, with the facility staff responsible. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21565		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written	21685		8/18/15

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21685	Continued From page 17 routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure exhaust fan duct work, lights above grill and screen in the kitchen were clean of dust and debris. This had potential to affect all residents, staff and visitors who consumed food from the kitchen. Findings include: During the initial tour of the facility kitchen with registered dietician (RD) on 7/20/15, at 1:15 p.m.; six metal caged lights above the grill where the food is cooked, were covered with 1/4 inch visible thick dust and debris from the light fixtures. In addition there was a 12 inch long by 6 inch window screen above the kitchen sink was completely covered in a black dust and debris. An additional tour was completed on 7/21/15, at 7:30 a.m. the lights and screen were still observed to be covered with visible dust and debris. During interview 7/21/15, at 8:15 a.m. dietary manager (DM) stated the lights were covered in dust along with the screen and the maintenance department was in charge of cleaning those. The DM stated the maintenance has a staff of 5 and 3 of them are on light duty so things just are not getting done. During interview 7/21/15, at 8:30 a.m. the maintenance manager (MM)-A stated they have a contracted service that cleans the overhead hood vent two times a year. The maintenance	21685	corrected areas cited were cleaned on 7/21/15	

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21685	Continued From page 18 director did inspect the lights and the screen and stated "That doesn't cut it" and expressed it is still the expectation to complete needed tasks. Review of the facility contracted cleaning service document form Fire Protection Equipment Co. After Service Follow Up Report dated 9/22/14, indicated the kitchen exhaust system hood was cleaned but not to code due to them being inaccessible. The recommendations indicated to "replacing box-style fan with upblast style to better access duct work." The company was out again on 3/2/15 and the Fire Protection Equipment Co. After Service Follow Up Report recommended "replacing box-style down blast fan with upblast fan to access fan and duct work. Replace damaged filters." During interview 7/22/15, at 2:00 p.m. the MM-A stated the "fan blows down and then diverts the air up to create a vacuum up and out of the roof". The MM then stated the fans should be cleaned, but that is how this style exhaust fan works and it is grandfathered until we remodel the kitchen at some uncertain time. During phone interview 7/22/15, at 2:15 p.m. with representative from the Fire Protection Equipment Co. stated the fan and ducts are inaccessible because they were unable to see down to the bare metal. The system was very old, which was probably manufactured in 1960's or 70's, and recommended a new unit. The facilities Nutritional Services Cleaning Procedure Equipment Hood policy undated indicated 1. the inside and outside of the hood will be cleaned once per month 2. clean the inside and outside of the hood	21685		

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21685	Continued From page 19 3. clean the light fixtures within the hood. Remove the light fixtures and clean with soap 4. use a brush or cloth as needed to remove grease and/or dust 5. wash hood with soap and water 7. the interior section of the hood that extends to the roof is cleansed semi annually by a commercial hood-cleaning operator. SUGGESTED METHOD OF CORRECTION: The Administrator and / or designee could review the cleaning schedule within food service and determine the frequency that high areas should be cleaned. TIME PERIOD FOR CORRECTION: Seven (7) days.	21685		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified rising and morning routines for 2 of 8 residents (R50 and R12),who required extensive staff assistance to complete activities of daily living (ADL's).	21805	corrected 8/14/15	8/14/15

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21805	Continued From page 20	21805		

R50's diagnoses, as identified on the care plan (CP), reviewed 6/6/2015, included hemiplegia, dementia, and aphasia. The quarterly Minimum Data Set (MDS), dated 5/27/2015, indicated R50 had severely impaired cognition, required extensive, physical assistance for ADL's, including two-person assist with bed mobility, transfers, toileting, dressing and personal hygiene.

During observation on 7/22/2015 at 7:11 a.m., R50 was lying on her back, in her bed, with her left hand positioned on top of her chest. R50's blanket was at the foot of the bed, pulled onto the resident, exposing R50's left leg, and one could see she already had pants on as she lied in bed. R50 remained in bed until 8:41, when NA-F and NA-G assisted her with morning cares. R50 was already dressed, with pants, socks and shirt, when NA-F removed R50's covers and checked for incontinence, NA-F and NA-G assisted R50 into her wheel chair with use of a mechanical lift. NA-F then brushed her hair, and NA-G assisted in placing R50's hand splint and arm into the wheel chair armrest and R50 was up for the day.

During an interview on 7/22/2015 at 8:38 a.m., NA-G said R50 was already dressed this morning, and we "just needed to get up, out of bed." NA-G said R50 needed "total assistance" dressing, and R50 was not able to verbalize her needs to staff.

In an interview on 7/22/2015 at 9:18 a.m., NA-F acknowledged R50 was dressed this morning when she assisted R50 to get up for the day. NA-F did not know who worked with R50, but said "someone on nights [the night shift] got her dressed," and that was typical for R50's routine. NA-F also said R50 would not be dressed early

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21805	Continued From page 21 on Tuesdays, "because she gets a bath on that day." During an interview on 7/24/2015 at 6:00 a.m., NA-H stated she works on the overnight shift, and routinely got R50 "cleaned up and dressed," but not removed from bed, "the day shift would do that." NA-H stated she does not get R50 dressed on her scheduled bath days. She has a list of residents whom she helped get cleaned and dressed, prior to the end of the night shift. NA-H said "I just need to make sure they are dressed and ready to go. I get them dressed and then put them back to bed; it helps out the morning shift." NA-H said if there was a resident that did not want to get up, she was instructed "to get someone else up." NA-H did add that some of the residents she assisted "liked to get up early," and there were some who simply "were up all night anyway." During an interview on 7/24/2015 at 1:06 p.m., family member (FM)-A said he was unaware staff were getting R50 dressed, then having her stay in bed. FM-A said that depending on the night, R50 was often awake late, or was "up at 3:00 a.m. and restless, and they [staff] will get her up." FM-A than stated, "I would think if [R50] got dressed, she'd be getting out, and up to breakfast for the day." In an interview on 7/24/2015 at 1:17 p.m., the director of nursing (DON) stated the night shift try "to help the day shift staff." The DON said "If someone was trying to get up, then get them up, and keep [the resident] from getting out of bed and possibly fall." In the same interview, the social worker (SW) said getting a resident up during the night was "not just a decision for the aide. We should look into this some more."	21805		

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21805	Continued From page 22 R12's quarterly minimum data set (MDS), dated 5/18/15, indicated she was severely, cognitively impaired and required extensive assist for transfers, dressing and grooming. The care plan (CP), dated 8/28/13, directed staff to give R12 opportunities to make daily preferences choices, including clothing, bed time and bathing. The CP also indicated R12 had an alteration in sleep, related to insomnia, with a goal of at least six hours of sleep at night. The CP did not address a morning routine preference of when R12 wanted to get up. During observation on 7/22/15 at 7:00 a.m., R12 was noted fully dressed and seated in her wheel chair. R12 was positioned in front of the television in the common area on the east wing, asleep in her wheelchair. R12 repeatedly made jerking movements as she dozed. R12 remained in chair until 8:15 a.m., (75 minutes) when staff approached, and awakened her. The staff asked R12 if if she wanted to go back to bed, or eat breakfast. R12 replied "I don't care." During an interview on 7/24/15, at 5:59 a.m., NA-E stated she was instructed to get four residents up, washed and dressed when working the over night shift. NA-E stated if a resident had shower, there was another one assigned to get up in their place. NA-E stated she will usually "get the residents up, washed, dressed and put them back to bed." During an interview on 7/24/15 12:24 p.m., licensed practical nurse (LPN)-C stated, " usually the over night shift is getting up the early risers, she stated they are not getting up anyone that would normally sleep in. LPN-C further stated,	21805		

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21805	Continued From page 23	21805		

"Some of the Hoyers [residents who require use of a mechanical lift to transfer] get washed, dressed and put back in bed, I don't have any idea why they would do that."

During an interview on 7/24/15, at 1:16 p.m., the director of nursing (DON) stated, there are many people getting up and dressed and put back to bed on the night shift. She stated, The nurses and care coordinators schedule them to help the day shift. The DON further stated, "the people on this list are usually up or crawling out of bed," we like the night shift to help day shift "get a jump on the day." She further stated, "I'm sure we are not the only nursing home in the world that does that." The intent is to help day shift out and prevent falls. The DON stated she was not sure if the rationale for waking a resident on night shift to get them washed and dressed is on the care plan or not.

During an interview on 7/24/15, at 2:07 p.m., registered nurse (RN)-C stated, We schedule residents for the night shift to get up, washed and dressed. She stated, We usually look at people who are trying to get up but if there aren't enough people who want to get up, we will pick people who are a "Hoyer lift." The aides will wash and dress them in bed. RN- C stated, "If someone prefers to get up early it is not care planned." She further stated, there is no one currently on the East unit that is care planned to get up early due to fall risk. RN-C stated, The rationale for night shift getting resident's washed and dressed is due to the workload in the morning.

Review of the facility's undated East night group sheet directed night shift to complete morning cares, oral cares, dressing, making bed and cleaning up room for five residents on the unit,

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21805	Continued From page 24 including R12. A review of the facility policy, Rights and Responsibilities of Patients/Residents, dated 4/15, indicated the facility "must, with courtesy, promote care for [residents] in a manner that maintains and enhances dignity and respect in full recognition of [a resident's] individuality." SUGGESTED METHOD OF CORRECTION: The Administrator and/or designee could inservice facility staff in regards to provision of care in a dignified manner. They could create an auditing system to ensure residents are being treated with dignity. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21805		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined	21990		8/21/15

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MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

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21990	Continued From page 25 in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure all allegations of abuse, neglect, mistreatment and injuries of unknown were immediately reported to the adminstrator and state agency, were thoroughly investigated, and residents were protected during their investigations for 8 of 15 residents' (R47, R12, R22, R39, R11, R66, R44 and R8) allegations reviewed. The facility failed to conduct reference checks for 4 of 5 newly hired employees (NA-A, NA-B, DA-A and RN-B). Findings include: Investigation and Protection During interview 7/23/15, at 5:09 p.m. with social worker (SW) stated that nursing assistant (NA)-C has been implicated in four incident reports from January 2015 to July 2015 as the potential alleged perpetrator (AP). Review of facility Incident and Investigation reports indicated the following: R47's quarterly Minimum Data Set (MDS) dated 2/17/15, indicated she was moderately cognitively intact and needed extensive assistance in ADLs. R47's care plan dated 2/26/15, indicated she had dementia and needs assist with dressing, grooming and bathing. The care plan further indicated she had slight alteration in cognition related to dementia and that resident will continue to be oriented to person, place and time.	21990	corrected8/21/15	

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Mille Lacs Nursing Home Progress Notes dated 1/24/15, at 3:49 a.m. indicated: "This nurse [LPN-D] was in a res. room, 5 rooms away from where the incident happened, but heard a distinct smack. Followed by a woman's out cry. This nurse then got a call on the walkie [walkie-talkie] from the aide. The aide stated (in her words) On 2 a.m. rounds, I went to check resident in room 45-1 and woke up resident in 45 -2 [R47] in the process. I told [R47] the time and said she should lay back down and try and get some sleep until coffee time. [R47] said "No, I want to sit up I'm waiting." NA-C said "No lets lay down" and NA-C went to pick up [R47's] feet to bring them in bed and [R47] swung and hit me in the head, fairly hard. I [NA-C] yelled out "ow" and NA-C said "why did you hit me, R47 said "I didn't, you hit me you liar" then [NA-C] walked out and walkie the nurse...." This nurse [LPN-D] asked the res. why she hit the aide. Res. [R47] stated that the aide hit her."

An Incident Report submitted to the state agency on 1/28/15, indicated that R47 had a conflict with a nursing assistant on 1/24/15. Following a review of the related progress notes, and supervisory staff, it was originally determined R47's incident was due to her dementia. Further study revealed that R47 allegedly struck a nursing assistant, but resident [R47] also alleged the nursing assistant struck her. The report indicated a further investigation needed to be completed.

A follow-up Investigative Report was submitted to the state agency on 2/2/15. The report indicated the SW met with the resident R47 on the a.m. of 1/28/15 and 1/30/15 and resident was unable to recall any incidents of concerns. The SW was unable to speak with NA-C until 2/2/15 (7 days

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after the SW learned of the situation) in part due to her work schedule not coinciding with the SW. SW spoke with NA-C by phone on 2/2/15, at 10:45 p.m. NA-C acknowledged the incident happened as described by LPN-D's note. NA-C stated she had not struck R47 in any way, but had tried to lift R47's legs to help her lay down. The investigative report indicated the AP was NA-C. This report also included that NA-C had been implicated in a previous submitted report.

During interview 7/23/15, at 5:10 p.m., the SW stated the resident was unable to recall if the incident had happened, and said R47 had dementia. The SW said NA-C was not suspended during her investigation because it could "not be proved" that NA-C abused R47, and R47 continued to be on the work schedule. The SW said NA-C was counseled on how to provide cares for R47, and was asked for ideas from NA-C on how to keep R47 safe.

Review of the facility's MLHS-LTC NA/R Schedule indicated NA-C was not suspended pending the investigation of the incident dated 1/28/15 and NA-C was scheduled to work 1/28/15 and 1/29/15, while the investigation was in progress.

The investigation of this incident lacked timely interviewing of the NA-C. This incident occurred on 1/24/15 but was not reported to the SA until 1/27/15. The investigation did not determine if the R47 was actually abused. The facility did not suspend NA-C or take action to protect residents, during the investigation. There was no indication that a thorough investigation was completed for R47.

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21990	Continued From page 28 R47 had another facility Social Service Incident Referral Form (SSIRF), signed by RN-C indicated R47 was involved in an incident on "3/2/15 early a.m., of possible abuse or resident aggression." The SSIRF indicated: RN-C noted PCC notes (electronic progress notes) by LPN-B questioning verbal statements and other behaviors by resident [R47]; possible indication of maltreatment but just a likely symptoms of resident's dementia." The SSIRF further indicated the incident was discussed with Investigative Team on 3/3/15 at 8:30 a.m., and reported submitted to the state agency on 3/3/2015 at 12:30 p.m. The report also indicated NA-C was a person with credible knowledge of the situation. An initial Incident Report was submitted to the state agency on 3/3/15 regarding possible abuse of R47 on 3/2/15. The report referenced "two progress notes from NOC (night) shift early that a.m. of 3/2 that suggests either some behavioral concerns/dementia symptoms by resident [R47] at work or possible maltreatment of resident by staff." The report indicated uncertainty by staff on whether this was maltreatment, and "SW decided to go ahead and submit the allegation to [state agency]...." A nursing progress note, dated 3/2/215 at 4:03 a.m., written by LPN-B, indicated [R47] was "kicking at staff" and [R47] told staff "she was going to report 'her' to the nurse.." The note also indicated R47 told staff "you go around hitting everyone I heard.." On 3/2/15 at 6:03 a.m., a second progress noted indicated staff went to wipe dry blood off [R47's] lip, and [R47] hit staff. The note continued, that after R47 hit staff, R47 stated "I am going to report you for hitting me."	21990		

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Facility documentation did not indicate any action was taken to protect R47 and other residents during this investigation of potential abuse. Documentation of the investigation of this incident did not include determination the cause of R47's bloody lip, and there was no evidence of interview with the nursing assistant who provided cares for R47. The SSRIF also indicated there was no immediate reporting of this incident to the state agency or administrator.

A final, Investigative Report was submitted to the state agency on 3/06/15 regarding the incident. The report indicated on 3/2/15 the "resident was interviewed by RN Care Coordinator (RN- A) and this SW. Resident denied remembering anything happening this past weekend during the daytime or the nighttime that upset her in any way.....She denied that anyone hits her or has been mean to her or that she has hit anyone else." The report also indicated "SW communicated with [LPN-B] about progress notes from 3/2/15 during night shift, "indicating the NAR was situating resident in the EZ lift (mechanical lift) to help her to the bathroom per resident's request and the NAR noticed resident's lip had been bleeding apparently cracked from being chapped with dry, winter air. [NA-C] told [R47] she was going wipe the dried blood off, but R47 struck out at NA, causing NA's glasses to dismount from her face." The report indicated NA-C re-approached later and assisted [R47] without incident. Later the same night, the NA was doing rounds and attempted to lift R47's feet back in bed, and resident kicked at NA-C. The report then referenced the allegations made by R47, that she was slapped. The report did not confirm a perpetrator in this incident. The report indicated R47's care plan was reviewed, and suggestions were made on how to approach R47 during

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cares. The report also indicated LPN-B was coached by the SW and DON on more thorough progress note charting, and further, that staff have been reminded to submit timely incident reports. The report included: "Something is just not resting well with this, and although there is no maltreatment of residents 'substantiated' in this particular incident, SW will continue to keep eyes and ears open for patterns and/or trends in conduct, etc."

Review of the facility's MLHS-LTC NA/R Schedule from February 23, 2015 to March 8, 2015, indicated NA-C was assigned to work 3/2/15 (the night of the alleged incident) and also worked on 3/3/15.

During interview 7/23/15, at 5:30 p.m. the SW stated, in review of this incident, she had "concerns with NA-C" but again could not prove she had really done anything wrong. The facility felt they could not substantiate the allegations against NA-C, and therefore did not warrant a "suspension or discipline" during the investigation. There was no indication that a thorough investigation was completed for R47.

R12's quarterly MDS dated 4/27/15 indicated she was moderately cognitively intact and needed extensive assist with dressing, bathing and grooming. R12's care plan dated 1/31/15, indicated she had potential for abuse from others related to cognitive impairment and limited mobility.

An initial Incident Report submitted to the state agency on 2/18/15, indicated that on 2/18/15, R12 was allegedly slapped, on her cheek, by a staff person who was attempting to administer

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medicine. The AP on the Incident Report was listed as unknown.

A final Investigative Report was submitted to the state agency on 2/23/15, regarding the incident. The report indicated R12 had made numerous allegations, but the only allegation that could be "tracked," was the one about someone slapping [R12] during the administration of Milk of Magnesia (MOM) that morning. Firstly, the report indicated the SW and DON proceeded to seek more information about who would have administered the MOM that morning. Per schedule, LPN-B and NA-C were the persons on duty. At 10:45 p.m. on 2/19/15, the DON and SW met with NA-C, who freely admitted having given MOM to R12 under direction of LPN-B. NA-C said "[R12] didn't want the MOM, and [R12] took the cup and threw the MOM all over." [NA-C] tried to clean it up off the bedding, resident's clothing and her face, using wet wipes." The report indicated NA-C denied slapping R12 in any way, but acknowledged wiping R12's face off with the wet ones. The report indicated, "It is possible this was perceived by [R12] as a slap." The SW asked NA-C to go to resident's room to see if resident could/would or would not identify her as the lady who slapped her, and NA-C agreed to do so. [R12] was sleeping soundly, however, so decided not awaken her. The report indicated "[NA-C's] willingness to go, however, leads SW to believe she [NA-C] is being truthful about not slapping resident." The report then indicated the DON spoke to LPN-B by phone on 2/23/15 at 3:20 p.m. LPN-C admitted asking NA-C to give MOM to R12 due to LPN being occupied elsewhere LPN-C also acknowledged that NA-C did report [R12's] claim of being slapped by a "blonde lady." The report then indicated staff have been alerted to have two

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persons present during cares with this resident and NA-C was instructed not to enter room without a colleague present.

During interview on 7/23/15, at 5:20 p.m. the SW stated she did not suspend NA-C since they could not prove NA-C slapped R12. The SW acknowledged NA-C had been involved in multiple incidents, and had "suspicions" with [NA-C], but did not feel "there was a reason to suspend" or provide disciplinary action to her during this investigation.

The investigation of this incident by the facility did not determine if R12 was slapped, nor was there follow up to have R12 positively identify the nursing assistant who provided cares. Although NA-C was instructed not to enter R12's room without a colleague present, the documentation offered no indication protections were put in place for other residents who were assisted by NA-C during this investigation of this incident, regardless of its outcome.

R22's admission MDS dated 4/24/15, indicated she had depression and a cerebral vascular accident (CVA), was moderately cognitively impaired and needed limited assist with transfers and extensive assist with toileting. R22's care plan dated 5/3/15, indicated she needed assist with toileting and transfers, had history of depression and sadness/isolating self. R22's care plan further indicated she had potential for abuse from others related to her general weakness, aches and pains. The care plan goal indicated "resident will remain safe and have needs met in a safe environment."

During observation on 7/20/15, at 5:54 p.m. R22

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lifted her pant leg and displayed a bruise on her right shin measuring approximately 8 cm (centimeters) x 2 cm.. R22's bruise was black, fading to dark purple in color, with no apparent swelling

In an interview 7/20/15, at 5:54 p.m. R22 stated that she had been treated "roughly by the staff" and there is a staff member who works the night shift that is rough with her. R22 went on to state this staff member had "grabbed her arm when transferring" which caused a large bruise and also stated she had also hit her leg into the metal bar along the bottom of her bed.

The facility submitted an Incident Report to the state agency on 6/27/15, regarding an incident of alleged mistreatment and physical abuse of R22. The report also identified a bruise on R22's top right hand, measuring 5.5 cm x 5 cm, circular in shape; and a second bruise on R22's lower right shin 2.5 cm x 2.5 cm, circular in shape. The report was submitted by RN-D, and indicated that the initial reporter, NA-A, was also the alleged perpetrator in this incident. The report indicated, nursing assistant (NA)-C reported at 5:15 a.m., she had toileted R22, After being toileted, R22 told [NA-C] she was not coming back tonight,and that "some girl hurt her." NA-C asked who, and she [R22] stated she doesn't know who. The report then indicated that registered nurse (RN)-A, followed up with R22 in the morning and asked her to tell her what happened: "Resident reported she is not staying here again tonight and is not going to be treated like this anymore." R22 explained that staff was mad at her during the night for getting up to use the bathroom so many times, and that a "girl grabbed me and threw me into bed." R22 pointed out her hand hurt, and said "this is where she grabbed me," noted a

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bruise on top of right hand measures 5.5 cm (centimeters) x 5 cm circular is shape. R22 also reported when she threw me into bed, "I hit my leg on something metal;" a bruise noted on right outer lower shin measures 2.5 cm x 2.5 cm circular in shape. R22 could not recall who the girl was, nor her name. R22 thought it was around 0400. The report further indicated NA-C was the nursing assistant working on that wing during the night, and LPN-A was the nurse in charge. No other injuries noted, resident was reassured she will remain safe here, NA-C will be removed from working with resident at this time.

An additional Incident Report was submitted to the state agency on 7/1/15, which identified an injury of unknown source on R22's right forearm 8 x 5 cm, reddish purple in color, and oval in shape. The date of incident occurrence was unknown. The report indicated R22 said, "It happened a few days ago."

An Investigative Report was submitted to the state agency on 07/02/15, which combined the two submitted incident reports. The report indicated the DON and social worker SW "have tried to investigate this issue thoroughly and have been unable to substantiate who the alleged perpetrator [AP] is for certain, but have reached a conclusion there is reasonable suspicion a crime may have occurred in the form of assault, and are hence submitting a report also to law enforcement, in accordance with Elder Justice Act." Further, "The details of our internal investigation to the limits of our ability are being submitted to OHFC [Office of Health Facility Complaints] the state agency." The Investigative Report further indicated on 7/1/15, the DON and SW met with the AP, (NA-C) who stated R22 had requested to use the toilet 6-8 times that night

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(6/27/15). The report then indicated [SW and DON] "discussed with the AP the number of previous incidences involving this NAR, which can raise red flags re [regarding] her credibility, and she became somewhat defensive, face reddening and voice tightening, saying 'it's because I report things and others don't, so I end up getting in trouble.'" The report further listed, that during an interview 7/2/15 the DON and SW meet with NA-D, who stated she "reported having heard from resident (R22) on 6/30, that [R22] is afraid of the girl with the blonde hair and bangs, that she is not very nice, etc. The blond hair with the bangs fits description of NA-C. The report further included that NA-C had been "implicated in previous reports 75814, 78740, and 79433 with possible "power struggles" with residents, as she tries to perform cares; received coaching in these incidents. NA-C was also involved in report 79866 but was not specifically named as AP."

Although R22 had described NA-C as the staff member who had hurt her and NA-C was caring for her and received multiple large bruises, no disciplinary action was taken, NA-C was not suspended pending the investigation. Also, there was no indication that a thorough investigation was completed by the facility to include other interviews with staff and residents.

During interview on 7/23/15, at 4:50 p.m. the DON stated she has concerns that NA-C might be doing the accusations, but stated she was not certain. The DON said, "Staff monitor [NA-C] during the night shift," and "we have nurses on that do that." The DON stated the nurses were to report if they notice anything and have concerns.

In an interview on 7/23/15, at 5:03 p.m. the SW stated she did not talk with other residents or staff

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regarding abuse allegations by R22. The DON stated, "I don't generally do that, it's not a witch hunt." The DON said, "Just because their name keeps coming up does not make them guilty." The DON also said there were issues around "data privacy and confidentiality." SW further stated when something regarding abuse allegations come up over the weekend, the nurse on duty initiates the OHFC reporting. The SW said the nurse would talk to the resident, and address any immediate concerns. Regarding NA-C, the SW stated, "At times there have been several residents she is not allowed to care for, but that does change if, during the investigation the allegation is not substantiated." The SW further stated, in regard to NA-C, after the first allegation of abuse, "a lot of coaching was done." The SW also said the coaching for NA-C was "not intensive, and there was no improvement plan initiated and no documentation of education or mentoring done."

During an interview on 7/23/15 at 5:10 p.m., the administrator said, "We have three young people working on nights, we can't suspend; there is not enough staff." The administrator further stated, " I feel the DON and SW did the right thing."

During an interview on 07/23/15, at 5:14 p.m. the DON stated NA-C was not suspended per the facility policy following the allegation made by R22 . She stated, "If I had suspended one, I would have had to suspend all three staff, then who would take care of the residents?"

During an interview on 07/24/15, 5:14 a.m., NA-E stated, " I don't work a lot of overnights unless I am mandated, but I do hear a few things." NA-E stated, "I have heard about people being super wet and I have heard that some of the girls are a

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little rough, but I can't tell you who." She further stated one of the residents mentioned about a girl being rough and leaving bruises. NA-E described the staff member as they were described by the resident and stated the resident said " the girl threw me into the chair because I had to go to the bathroom again." NA-E stated she does not see the nurse a lot on nights.

During interview on 7/24/15, at 5:25 a.m. LPN-H stated she works part time on the night shift. LPN-H stated she has heard from other NAs that NA-C is rough with the residents but had not witnessed it directly. LPN-H stated she was not aware that she was to monitor any staff during the night shift when she works. She further indicated she had heard R12 had reported that NA-C had slapped her and that NA-C no longer works on the North wing and thought the reason was because of the cat; not because she can not take care of any certain residents. She then stated the aides on the night shift don't work together they prefer to work on each unit alone.

INJURIES OF UNKNOWN ORIGIN

R39's annual MDS, dated 3/9/15, indicated she was moderately cognitively impaired. Her care plan, dated 3/30/15, indicated she required extensive assist with all activities of daily living, used a mechanical stand for transfers, and was at risk for abuse related to dementia.

Review of Social Service Incident Report Form, dated 10/7/14, indicated R39 had a large, dark purple bruise on the right upper portion of her buttock and that R39 was unaware of how the bruising occurred. The report indicated R39 had been lowered to floor by staff a few days prior to

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21990	Continued From page 38 the bruise and indicated that may have caused the injury. The incident further indicated use of anticoagulant medication (used to prevent clotting) , other injuries/incidents over an unspecified times frame, and listed the injury as "minor." The injury was not reported to OHFC. During an interview on 7/24/15, at 12:54 p.m., the DON)stated, when R39 had been lowered to the floor it would be hard to know if injury occurred during that event but stated, R39 bruised easily due to use of anticoagulant medication so therefore the injury was not considered reportable. Although R39 was moderately impaired and unable to recall how the bruise occurred, there was no evidence that a more in-depth investigation was completed to determine the actual cause, nor was R39's injury of unknown origin reported to the state agency. R11's quarterly MDS, dated 4/15/15, indicated she was moderately cognitively impaired. Care plan, dated 6/3/15, indicated R11 required extensive to total assist for all activities of daily living, was cognitively impaired, and at risk for abuse related to depression. Review of three separate Social Services Incident Report Forms indicated R11 had injuries of unknown origin. An incident form dated 10/21/15, indicated R39 had a bruise to the top of her right hand that was dark purple in color and measured 8 cm x 8 cm. The report further indicated R11 was unable to state how the injury occurred, used blood thinners and described the injury as "minor." Another Social Services Report Form,	21990		

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21990	Continued From page 39	21990		

dated 11/4/14, indicated R11 had bruising noted to her left temple and above her left eyebrow, and was unable to state the cause of the injury. A third incident report dated 12/18/14, indicated R11 had a bruise of unknown origin to her left inner knee, dark purple in color, measuring 1 x 1 3/4. (unit of measurement was not indicated). The report further indicated R11 was unable to report the cause of the injury, use of anticoagulant medications, and the injury was considered to be " minor." None of the three bruises were reported to OHFC.

During an interview on 7/24/15, at 12:54 p.m., SW stated, R11 "had more bruising than anyone I have ever known." She stated the bruise on R11's hand may have been caused by "recent trimming of [R11's] nails." Regarding the bruise noted to R11's temple and forehead, SW stated that nursing felt the bruising was due to placement of R11's nebulizer mask, however, SW interviewed R11 who reported that she slipped and fell on her way back from supper. SW further stated R11 did not ambulate, used a Hoyer lift for transfer and there were no records of any falls and indicated the bruising was likely due to placement of R11's nebulizer mask.

During an interview on 7/24/15, at 12:54 p.m., the DON stated R11 could reliably answer when asked if bruising was related to abuse, therefore, she felt the injury was not reportable.

Although R11 was identified to be moderately cognitively impaired, and had multiple bruises at different locations, and were unable to determine what happened, there was no indepth investigation completed to determine the actual causes of R11's bruises. The facility administrator was notified but none of these incidents were

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21990	Continued From page 40 submitted to the state agency. R66's quarterly MDS, dated 1/7/15, indicated she was moderately cognitively impaired. Care plan, dated 2/9/15, indicated R66 required extensive assist of two staff with use of mechanical lift for transfers, at risk for delirium, and at risk for abuse related to depression. During review of a Social Service Incident Referral Form, dated 2/3/15, a facility progress noted indicated R66 had bruising along both arms from her hands to her shoulders. The form further indicated R66 was unable to state the cause of the injury and that the injury was assessed to be "minor." The injury was not reported to OHFC. During an interview on 7/24/15, at 12:54 p.m., SW stated, the bruises were noted while the DON was reviewing a progress note and she spoke with nursing and determined the bruising was assessed to be a minor injury and therefore not reportable to to OHFC. During an interview on 7/24/15, at 12:54 p.m., the DON stated, R66 used a Hoyer lift (mechanical lift) and did not always cooperate in lift, occasionally "flailing her arms." She further stated, R66 was confused and that it would be "hard to say if R66 would have been able to to talk about how the bruising occurred after any time had passed." Although R66 had bilateral bruising from her hands to her shoulders, the injury was unwitnessed and the resident was unable to identify what happened. The facility had not immediately reported the incident to the state agency nor was a thorough investigation	21990		

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21990	Continued From page 41 completed to determine if R66 was "flailing her arms" while using the mechanical lift. R44's annual MDS, dated 6/9/15, indicated she was severely cognitively impaired. Care plan, dated 7/10/15, indicated R44 required extensive assist with activities of daily living, and was at risk for abuse related to short term memory loss and impaired decision making skills. Review of Social Service Incident Referral Form, dated 6/15/15, indicated R44 had a purple bruise on her posterior forearm measuring 6.3 cm x 7 cm that was found during her bath. The incident form indicated R66 did not state the cause of injury and that the injury was determined to be "minor."The bruise was not reported to OHFC. During an interview on 7/24/15, at 12:54 p.m., SW stated, on 8/18/14, staff reported R8 had a bruise measuring 8.5 cm in length between her thumb and forefinger from the base of the thumb to her wrist. She stated the reporting nurse did the initial evaluation and determined the bruising resulted from R8 wringing her hands, and the wringing of her hands was witnessed by staff. She further stated the injury was not reportable due to staff witness of the potential cause. A Social Services Incident Referral form was requested for this injury but was not received. During an interview on 7/24/15, at 12:54 p.m., SW stated when making a determination of whether or not to report an injury to OHFC, she refers to statutes, and uses a decision tree. SW also stated that she looks at whether a resident is able to explain the injury or if someone else saw	21990		

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21990	Continued From page 42	21990		

it, and if there is a history of other recent falls and/or injuries. She further stated, if the nurses indicated minor injury or injury not suspicious in nature or location, it does not need to be reported.

During an interview on 7/24/15, at 12:54 p.m., the DON stated, there was no criteria for determining whether an injury was minor vs major. She further stated, the nurse finding the injuries did initial evaluation to determine the above injuries to be minor. The DON stated she would use the nurses judgement when determining if an injury was minor or major and that the RN in charge followed up on the injuries. However, she stated there was no charting in the clinical record that would show evidence that follow up had been completed.

Even though R44 was assessed to be severely cognitively impaired, had an injury of "unknown" origin, on the posterior of her arm. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency.

R8's quarterly minimum data set (MDS) identified her to be severely cognitively impaired and requiring assist of two staff for activities of daily living. CP dated 5/15/15 indicated R8 required extensive assist for activities of daily living and was at risk for abuse related to diagnosis of dementia.

A review of SSIRF dated 8/18/14, indicated R8 had a bruise measuring 8.5 cm in length between her thumb and forefinger from the base of her

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21990	Continued From page 43 thumb to her wrist. The reporting nurse did the initial evaluation and determined the bruising resulted from R8 wringing her hands, and the wringing of her hands was witnessed by staff. During an interview on 7/24/15, at 12:54 p.m., SW stated, the injury was not reportable due to staff witness of the potential cause. No further investigation of the injury was completed. The facility administrator was notified of the injury but a report was not made to the state agency. A Social Services Incident Referral form was requested for this injury but was not received. Although R8 had severe cognitive impairment, and had a bruise 8.5 cm between her thumb and forefinger from the base of her thumb to her wrist. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency. Review of the facility Vulnerable Adult Policy, revised 7/15, indicated: "It is the policy of MLHS (Mille Lacs Health System) to protect adults who are vulnerable to abuse (including verbal, physical, mental psychosocial/emotional, and sexual abuse)..." The policy further indicated: "protection will include abuse prevention plans, individual abuse prevention plans, internal reporting of all cases of suspected abuse, neglect, or financial exploitation, and external reporting to the Common Entry Point (CEP) of substantiated incidents of maltreatment." In regard to investigation of a reportable incident,	21990		

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21990	Continued From page 44 the policy stated: "All alleged violations are thoroughly investigated. The facility must prevent further potential abuse while the investigation is in progress." Under the "Protection for Resident or Patient" section, the policy directed that "The alleged perpetrator (AP) will be removed from the situation. If the AP is an employee, they will be suspended until the investigation is completed," and further, "Disciplinary action will be carried out up to and including dismissal of employee/employees as appropriate." The Policy defined Injury of Unknown Origin as "...source of the injury was not observed and injury as suspicious." The policy did not expound on this definition top include CMS definitions. In regard to screening of potential employees, the policy directed "MLHS will attempt to obtain information from previous employers and/or current employers." SUGGESTED METHOD OF CORRECTION: The Administrator and/or designee could review and inservice the facility staff responsible for the investigation of allegations of abuse and neglect, to the State rules and facility policy. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21990		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its	22000		8/21/15

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22000	Continued From page 45 environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult.	22000		

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22000	Continued From page 46 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement their Vulnerable Adult Policy to ensure all allegations of abuse, neglect, mistreatment and injuries of unknown origin were immediately reported to the administrator and state agency, were thoroughly investigated, and residents were protected during the investigations for 8 of 15 residents' (R47, R12, R22, R39, R11, R66, R44 and R8) allegations reviewed. In addition, the facility failed to conduct reference checks according to their policy for 4 of 5 newly hired employees (NA-A, NA-B, DA-A and RN-B). This had the potential to effect all 50 residents who resided in the facility, and resulted in substandard quality of care under resident behavior and facility practices. Findings include: The facility Vulnerable Adult Policy, revised 7/15, indicated: "It is the policy of MLHS (Mille Lacs Health System) to protect adults who are vulnerable to abuse (including verbal, physical, mental psychosocial/emotional, and sexual abuse)..." The policy further indicated: "protection will include abuse prevention plans, individual abuse prevention plans, internal reporting of all cases of suspected abuse, neglect, or financial exploitation, and external reporting to the Common Entry Point (CEP) of substantiated incidents of maltreatment." In regard to investigation of a reportable incident, the policy stated: "All alleged violations are thoroughly	22000	corrected 8/21/15	

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22000	Continued From page 47 investigated. The facility must prevent further potential abuse while the investigation is in progress." Under the "Protection for Resident or Patient" section, the policy directed: "The alleged perpetrator (AP) will be removed from the situation. If the AP is an employee, they will be suspended until the investigation is completed," and further, "Disciplinary action will be carried out up to and including dismissal of employee/employees as appropriate." INVESTIGATION AND PROTECTION During interview 7/23/15, at 5:09 p.m. with social worker (SW) stated that nursing assistant (NA)-C has been implicated in at least four incident reports from February 2015 to July 2015 of alleged abuse, and neglect. Review of facility Incident and Investigation reports from 2/1/2015 to 7/20/2015 for NA-C identified the following: R47's quarterly minimum data set (MDS) dated 2/17/15, indicated she was moderately cognitively intact and needed extensive assistance in ADLs. R47's care plan dated 2/26/15, indicated she had dementia and needs assist with dressing, grooming and bathing. The care plan further indicated she had slight alteration in cognition related to dementia and that resident will continue to be oriented to person, place and time. A facility Social Service Incident Referral Form (SSIRF) indicated licensed practical nurse (LPN)-D verbally reported to the social worker (SW) on 1/27/2014, at 4 p.m., an incident that occurred during the night shift on 1/24/2015. The SSIRF, dated 1/27/15, indicated: "Alleged altercation/conflict between res [resident] & aides resulting in resident slapping aide and stating 'I	22000		

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didn't hit you, you hit me you liar.'" The SSIRF also indicated, "LPN separated aide & resident, assisted res to bed, escorted aide to hallway to inquire what happened." The SSIRF also indicated the incident required "further investigation and/or reporting" to the state agency, and this was signed by the SW on 1/28/15.

A review of Mille Lacs Nursing Home Progress Notes, dated 1/28/15, written by LPN-D indicated: "This nurse was in a res. room, 5 rooms away from where the incident happened, but heard a distinct smack. Followed by a woman's out cry. This nurse then got a call on the walkie [walkie-talkie] from the aide (nursing assistant, NA)." The [NA] stated (in her words) "On 2 a.m. rounds, I went to check resident in room 45-1 (room 45, bed 1) and woke up resident in 45-2 [R47] in the process. I told [R47] the time and said she should lay back down and try and get some sleep until coffee time." [R47] said "No, I want to sit up I'm waiting." NA said "No lets lay down" and NA went to pick up [R47's] feet to bring them in bed and [R47] swung and hit me in the head, fairly hard. I [NA] yelled out "ow" and NA said "why did you hit me, [R47] said, 'I didn't, you hit me you liar' then [NA] walked out and walkie the nurse...." This nurse [LPN-D] asked the res. why she hit the aide. Res. [R47] stated that the aide hit her." The nursing note did not identify the nursing assistant by name.

A facility email, written by the SW, dated 1/28/2015, indicated the SW had been verbally informed by LPN-D of R47 being in a conflict with a nursing assistant. The email indicated there was a progress note of the incident, but no further "incident report form." The email indicated the SW further reviewed the progress notes, and

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because the notes indicated "the resident allegedly struck a NAR [nursing assistant] and also that the resident claimed at the time that the NAR struck her, the incident DOES need to be reported" to the state agency.

An Incident Report submitted to the state agency on 1/28/15, indicated: "An incident was verbally reported to this SW in the late afternoon 1/27/15..." and further that R47 had a conflict "this past weekend" with a nursing assistant. Following a review of the related progress notes by the "Stand Up Team" and "Behavior Management Team", it was originally determined incident was due to [R47's] "dementia symptoms..." The report referred to a nursing progress note which indicated that [R47] "claimed at the time that the NAR struck her," thus requiring a report to the state agency, and "an internal investigation done accordingly as per policy." The alleged perpetrator (AP) was unidentified.

A review of the SSIRF, the internal email, and the initial report submitted to the state agency indicated an incident occurred sometime during the night shift/early morning hours of 1/25/14. The report also indicated the incident was first reported, and made known to the SW on late afternoon of 1/27/2014, (two days after the incident) and reported to the state agency on 1/28/2015 (three days after the incident allegedly occurred). There was no indication this incident was reported immediately to the administrator and state agency. Additionally, the investigation of this incident: lacked timely interviewing of NA-C, and other involved staff, and potentially affected residents; did not provide evidence R47 was thoroughly investigated for injuries; and lacked evidence of action to protect residents

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22000	Continued From page 50 during the investigation. A final Investigative Report was submitted to the state agency on 2/2/15. The report indicated the SW met with R47 "on the a.m. of 1/28/15 and 1/30/15," and "Resident unable to recall any incidents of concern with any aides the previous weekend." The SW was unable to speak with NA-C, (identified as the nursing assistant involved) until 2/2/15 (7 days after the SW learned of the incident) "in part due to her work schedule not coinciding with the SW." SW spoke with NA-C by phone on 2/2/15, at 10:45 p.m. NA-C "acknowledged the incident happened as described" by LPN-D's note, and further, "[NA-C] saying she had not struck resident in any way, but had merely tried to lift [R47's] legs to help her lay back down..." The report indicated "There is no apparent evidence of NAR striking resident." The investigative report indicated the alleged perpetrator was NA-C. This report also included that NA-C had been implicated in a previous submitted report. During an interview 7/23/15, at 5:10 p.m., the SW stated in the investigation, R47 was unable to recall if the incident had happened, and that R47 had dementia. The SW said NA-C was not suspended during her investigation because it could not be proven that NA-C abused R47, and NA-C continued to be on the work schedule. The SW said NA-C was counseled on how to provide cares for R47, and was asked for ideas from NA-C on how to keep R47 safe. Review of the facility's MLHS-LTC NA/R Schedule from January 26, 2014 to February 8, 2015, indicated NA-C worked on the night shift on 1/28/15 and 1/29/15, while the investigation of	22000		

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22000	Continued From page 51 this incident was in progress. R47 had another facility Social Service Incident Referral Form (SSIRF), signed by RN-C indicated R47 was involved in an incident on "3/2/15 early a.m., of possible abuse or resident aggression." The SSIRF indicated: RN-C noted PCC notes (electronic progress notes) by LPN-B questioning verbal statements and other behaviors by resident [R47]; possible indication of maltreatment but just a likely symptoms of resident's dementia." The SSIRF further indicated the incident was discussed with Investigative Team on 3/3/15 at 8:30 a.m., and reported submitted to the state agency on 3/3/2015 at 12:30 p.m. The report also indicated NA-C was a person with credible knowledge of the situation. An initial Incident Report was submitted to the state agency on 3/3/15 regarding possible maltreatment of R47 on 3/2/15. The report referenced "two progress notes from NOC (night) shift early that a.m. of 3/2 that suggests either some behavioral concerns/dementia symptoms by resident [R47] at work or possible maltreatment of resident by staff." The report indicated uncertainty by staff on whether this was maltreatment, and "SW decided to go ahead and submit the allegation to [state agency]...." A nursing progress note, dated 3/2/215 at 4:03 a.m., written by LPN-B, indicated [R47] was "kicking at staff" and [R47] told staff "she was going to report 'her' to the nurse.." The note also indicated R47 told staff "you go around hitting everyone I heard.." On 3/2/15 at 6:03 a.m., a second progress noted indicated staff went to wipe dry blood off [R47's] lip, and [R47] hit staff.	22000		

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22000	Continued From page 52 The note continued, that after R47 hit staff, R47 stated "I am going to report you for hitting me." Facility documentation did not indicate any action was taken to protect R47 and other residents during this investigation of potential abuse. Documentation of the investigation of this incident did not include determination the cause of R47's bloody lip, and there was no evidence of interview with the nursing assistant who provided cares for R47. The SSRIF also indicated there was no immediate reporting of this incident to the state agency or administrator. A final, Investigative Report was submitted to the state agency on 3/06/15 regarding the incident. The report indicated on 3/2/15 the "resident was interviewed by RN Care Coordinator (RN- A) and this SW. Resident denied remembering anything happening this past weekend during the daytime or the nighttime that upset her in any way.....She denied that anyone hits her or has been mean to her or that she has hit anyone else." The report also indicated "SW communicated with [LPN-B] about progress notes from 3/2/15 during night shift, "indicating the NAR was situating resident in the EZ lift (mechanical lift) to help her to the bathroom per resident's request and the NAR noticed resident's lip had been bleeding apparently cracked from being chapped with dry, winter air. [NA-C] told [R47] she was going wipe the dried blood off, but R47 struck out at NA, causing NA's glasses to dismount from her face." The report indicated NA-C re-approached later and assisted [R47] without incident. Later the same night, the NA was doing rounds and attempted to lift R47's feet back in bed, and resident kicked at NA-C. The report then referenced the allegations made by R47, that she was slapped. The report did not confirm a	22000		

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perpetrator in this incident. The report indicated R47's care plan was reviewed, and suggestions were made on how to approach R47 during cares. The report also indicated LPN-B was coached by the SW and DON on more thorough progress note charting, and further, that staff have been reminded to submit timely incident reports. The report included: "Something is just not resting well with this, and although there is no maltreatment of residents 'substantiated' in this particular incident, SW will continue to keep eyes and ears open for patterns and/or trends in conduct, etc."

Review of the facility's MLHS-LTC NA/R Schedule from February 23, 2015 to March 8, 2015, indicated NA-C was assigned to work 3/2/15 (the night of the alleged incident) and also worked on 3/3/15.

During interview 7/23/15, at 5:30 p.m. the SW stated, in review of this incident, she had "concerns with NA-C" but again could not prove she had really done anything wrong. The facility felt they could not substantiate the allegations against NA-C, and therefore did not warrant a "suspension or discipline" during the investigation. There was no indication that a thorough investigation was completed for R47.

R12's quarterly MDS dated 4/27/15 indicated she was moderately, cognitively intact and needed extensive assist with dressing, bathing and grooming. R12's care plan dated 1/31/15, indicated she had potential for abuse from others related to cognitive impairment and limited mobility.

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22000	Continued From page 54 A facility Social Service Incident Referral Form (SSIRF), signed by the SW 2/18/15 at 4:15 p.m., indicated there was an incident on "2/18/2015 early A.M.", which alleged "Abuse." The incident was described as: "[NA)-I] asked SW to meet w/ Res re some issues. 9:30 a.m. Res told SW 'I want to go home, they're mean to me here.' 'The lady with the ponytail hurt me when she clean me up yesterday', and 'The other lady slapped me when she tried to make me drink white stuff.' At 4p.m. resident [R12] was still claiming similar concerns." The SSIRF also indicated the following: an internal email report was completed on 2/18/15; that the report of alleged abuse was received by the SW in person, no date or time listed; the incident was discussed with "Investigative Team" on 2/18/15 at 0833; and that the state agency initial report was submitted on 2/18/15 (no time indicated). An initial Incident Report submitted to the state agency on 2/18/15, indicated on 2/18/15, R12 was "slapped on her cheek by a staff person early this morning while staff person was trying to get her to take some medicine." The report indicated R12 had no apparent injuries, and "has been consistent with this claim throughout the day..." The report also indicated "a full internal investigation is warranted." The "alleged perpetrator" on the report form was listed as "unknown." A review of the SSIRF, and the initial report to the State Agency indicated, that although this incident occurred in the early morning of 2/18/15, and possibly earlier, no action was taken by the facility or staff until it was discussed later that morning on 2/18/15. There was no indication the incident was immediately reported to state agency and administrator. Further, the investigation	22000		

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documentation of this incident did not indicate if R12 was slapped; and there was no follow up to have R12 positively identify the nursing assistant, (possibly NA-C) who provided her cares that day. Although NA-C was instructed not to enter R12's room without a colleague present, the documentation offered no indication protections were put in place for other residents who were assisted by NA-C during the investigation of this incident, regardless of its outcome.

A final Investigative Report was submitted to the state agency on 2/23/15. The final report indicated the "Initial Reports submitted to [state agency] ...at 4 p.m.," on 2/18/15, and also a call was made to local law enforcement. The report indicated R12 had made numerous allegations, but the only allegation that could be "tracked, was the one about someone slapping her during the administration of Milk of Magnesia (MOM) that morning (the white stuff)." The report indicated SW and DON proceeded to seek more information about who would have administered the MOM that morning. The report identified, according to the schedule, LPN-B and NA-C were the persons on duty. Further, the report indicated, "DON and SW met with [NA-C], who freely admitted having given MOM upon the direction of [LPN-B]." The report continued, "[NA-C] said resident didn't want the MOM, and resident took the cup and threw the MOM all over." and "[NA-C] tried to clean it up off the bedding, resident's clothing and her face, using wet wipes." The report indicated "[NA-C] denied slapping resident in any way, but acknowledged wiping R12's face off with the wet ones." The report indicated "It is possible this was perceived by [R12] as a slap." Next, the report indicated, the SW asked NA-C to go to resident's room to

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see if resident could or would identify her as the lady who slapped her, and NA-C agreed to do so. "[R12] was sleeping soundly, however, so decided not awaken her." The report indicated "NA-C's willingness to go, however, leads SW to believe she [NA-C] is being truthful about not slapping resident." The report indicated the DON spoke to LPN-B by phone on 2/23/15 at 3:20 p.m. LPN-C admitted asking NA-C to give MOM to R12 due to LPN-C being occupied elsewhere LPN-C also acknowledged that NA-C did report (R12's) claim of being slapped by a "blonde lady." The report then indicated staff have been alerted to having "two persons present" during cares with this resident and NA-C was instructed not to enter room without a colleague present.

During interview on 7/23/15, at 5:20 p.m. the SW stated she did not suspend NA-C since "they could not prove [NA-C] slapped [R12.]" The SW acknowledged NA-C had been involved in multiple incidents, and had "suspicions" with [NA-C], but did not feel "there was a reason to suspend" or provide disciplinary action to her during this investigation.

Review of the facility's MLHS-LTC NA/R Schedule from February 9, 2015 to February 22, 2015, indicated NA-C worked on 2/17/15 through 2/22/2015, that is on the date of the alleged incident, and during the subsequent investigation. There was no indication a thorough investigation was completed for R12.

R22's admission MDS dated 4/24/15, indicated she had depression and a cerebral vascular accident (CVA), and was moderately cognitively impaired and needed limited assist with transfers

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and extensive assist with toileting. R22's care plan dated 5/3/15, indicated she needed assist with toileting and transfers, had history of depression and sadness/isolating self. R22's care plan further indicated she had potential for abuse from others related to her general weakness, aches and pains. The care plan goal indicated "resident will remain safe and have needs met in a safe environment."

During observation on 7/20/15 at 5:54 p.m., R22 lifted her pant leg and displayed a bruise on her right shin measuring approximately 8 cm (centimeters) x 2 cm. R22's bruise was noted to be black, fading to dark purple in color, with no apparent swelling. In an interview 7/20/15, at 5:54 p.m. R22 stated that she had been treated "roughly by the staff" and there is "a staff member who works the night shift that is rough with her." R22 went on to state this staff member had "grabbed her arm when transferring" which caused a large bruise and also stated she had also hit her leg into the metal bar along the bottom of her bed.

The facility submitted an Incident Report to the state agency on 6/27/15 regarding an incident of alleged mistreatment and physical abuse of R22. The report also identified a bruise on R22 top right hand, measuring 5.5 cm x 5 cm, circular in shape; and a second bruise on R22's lower right shin 2.5 cm x 2.5 cm, circular in shape. The report was submitted by RN-D, and indicated that the initial reporter, NA-C, was also the alleged perpetrator in this incident. The report indicated, nursing assistant (NA)-C reported at 5:15 a.m., she had toileted R22, after being toileted, R22 told [NA-C] she was not coming back tonight,and that "some girl hurt her." NA-C asked who, and she [R22] stated she doesn't know who. The

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report then indicated that registered nurse (RN)-A, followed up with R22 in the morning and asked her to tell her what happened: "Resident reported she is not staying her again tonight and is not going to be treated like this anymore." R22 explained that staff was mad at her during the night for getting up to use the bathroom so many times, and that a "girl grabbed me and threw me into bed." R22 pointed out her hand hurt, and said "this is where she grabbed me," noted a bruise on top of right hand measures 5.5 cm (centimeters) x 5 cm circular is shape. R22 also reported when she threw me into bed, "I hit my leg on something metal" a bruise noted on right outer lower shin measures 2.5 cm x 2.5 cm circular in shape. R22 could not recall who the girl was, nor her name. R22 thought it was around 0400. The report further indicated NA-C was the nursing assistant working on that wing during the night, and LPN-A was the nurse in charge. No other injuries noted, resident was reassured she will remain safe here, NA-C will be removed from working with resident at this time.

An additional Incident Report was submitted to the state agency on 7/1/15, which identified an injury of unknown source on R22's right forearm "8 x 5 cm, reddish purple in color and oval in shape." The date of incident occurrence was unknown. The report indicated R22 said "It happened a few days ago."

An Investigative Report was submitted to the state agency on 07/02/15, which combined two submitted incident reports dated 6/27/15 and 7/1/15. The report indicated the director of nursing (DON) and social worker (SW) "have tried to investigate this issue thoroughly and have been unable to substantiate who the alleged perpetrator [AP] is for certain, but have reached a

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22000	Continued From page 59 conclusion there is reasonable suspicion a crime may have occurred in the form of assault, and are hence submitting a report also to law enforcement, in accordance with Elder Justice Act." Further the report indicated, "The details of our internal investigation to the limits of our ability are being submitted to OHFC and the state agency." The Investigative Report further indicated on 7/1/15, the DON and SW met with the AP, (NA-C) who stated R22 had requested to use the toilet 6-8 times that night (6/27/15). The report then indicated [SW and DON] "discussed with the AP the number of previous incidences involving this NAR, which can raise red flags re her credibility, and she became somewhat defensive, face reddening and voice tightening, saying 'it's because I report things and others don't, so I end up getting in trouble.' " The report further listed, that during an interview 7/2/15 the DON and SW meet with NA-D, who stated she "reported having heard from resident (R22) on 6/30, that [R22] is afraid of the girl with the blonde hair and bangs, that she is not very nice, etc. The blond hair with the bangs fits description of NA-C. The report further included that NA-C had been "implicated in previous reports 75814, 78740, and 79433 with possible "power struggles" with residents, as she tries to perform cares; received coaching in these incidents. NA-C was also involved in report 79866 but was not specifically named as AP." Although R22 had described NA-C as the staff member who had hurt her and NA-C was caring for her and received multiple large bruises, the incident documentation indicated no action taken to protect residents during investigation of these incidents. Also, there was no indication that a thorough investigation was completed that included other interviews with staff and residents.	22000		

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22000	Continued From page 60 During interview on 7/23/15, at 4:50 p.m. the DON stated she "has concerns that NA-C might be doing the accusations," but stated she "was not certain." The DON said, "staff monitor [NA-C] during the night shift," and also "we have nurses on that do that." The DON stated the nurses were to report to her if they notice anything and have concerns. In an interview on 7/23/15, at 5:03 p.m., the SW stated she "did not talk with other residents or staff regarding abuse allegations by [R22]." The DON stated, "I don't generally do that, it's not a witch hunt." The DON said, "Just because their name keeps coming up does not make them guilty." The DON also said there were issues around "data privacy and confidentiality." SW further stated, when something regarding abuse allegations come up over the weekend, the nurse on duty initiates the OHFC reporting. The SW said the nurse would talk to the resident, and address any immediate concerns. Regarding NA-C, the SW stated, "At times there have been several residents she is not allowed to care for, but that does change if, during the investigation the allegation is not substantiated." The SW further stated, in regard to NA-C, after the first allegation of abuse, " a lot of coaching was done." The SW also said the coaching for NA-C was "not intensive, and there was no improvement plan initiated and no documentation of education or mentoring done." During an interview on 7/23/15 at 5:10 p.m., the administrator said, "We have three young people working on nights, we can't suspend; there is not enough staff." The administrator further stated, " I feel the DON and SW did the right thing."	22000		

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22000	Continued From page 61 During an interview on 07/23/15, at 5:14 p.m., the DON stated NA-C was not suspended per the facility policy following the allegation made by R22 . She stated, "If I had suspended one, I would have had to suspend all three staff, then who would take care of the residents?" During an interview on 07/24/15 5:14 a.m., NA-E stated, " I don't work a lot of overnights unless I am mandated, but I do hear a few things." NA-E stated, "I have heard about people being super wet and I have heard that some of the girls are a little rough, but I can't tell you who." She further stated, one of the resident mentioned about a girl being rough and leaving bruises. NA-E described the staff member as they were described by the resident and stated the resident said " the girl threw me into the chair because I had to go to the bathroom again." NA-E stated she does not see the nurse a lot on nights. During interview on 7/24/15, at 5:25 a.m. LPN-H stated she works part time on the night shift. LPN-H stated she has heard from other NAs that NA-C is rough with the residents but had not witnessed it directly. LPN-H stated she is not aware that she is to monitor any staff during the night shift when she works. She further indicated she had heard R12 had reported that NA-C had slapped her and also that NA-C no longer works on the North wing and thought the reason was because of the cat not because she can not take care of any certain residents. She then stated the aides on the night shift don't work together they prefer to work on each unit alone. INJURIES OF UNKNOWN ORIGIN The facility Vulnerable Adult Policy, revised 7/15, defined Injury of Unknown Origin as "...source of	22000		

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22000	Continued From page 62	22000		

the injury was not observed and injury as suspicious." The policy did not expound on this definition to include criteria from the CMS interpretive guidance.

R39's annual MDS, dated 3/9/15, indicated she was moderately, cognitively impaired. The CP, dated 3/30/15, indicated R39 required extensive assist with all activities of daily living (ADLs), used a mechanical stand for transfers, and was identified at risk for abuse, because of dementia.

A review of SSIRF dated 10/7/14, indicated R39 had a large, dark purple bruise on the right upper portion of her buttock, and it was an "unknown" injury, and R39 was "unaware" of how the bruising occurred. The SSIRF also indicated R39 "a few days ago had been lowered to floor due to not standing when transferring & then lifted with Hoyer (a mechanical lift) Possible cause." The SSRIF further indicated R39 used a medication that could explain bruising, and also that R39's chart contained "falls or other recent incidents that could likely have produced the injury." The SSIRF indicated R39's injury was "minor" and not reported to the state agency. No further investigation was completed for this incident even though there was no indication R39 had struck any objects or the floor as she was lowered to the ground.

During an interview on 7/24/15, at 12:54 p.m., the DON stated, when R39 had been lowered to the floor "it would be hard to know if injury occurred during that event." The DON said R39 bruised easily due to use of anticoagulant medication, so therefore the injury was "not considered reportable."

Although R39 was moderately impaired and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00374	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
22000	Continued From page 63 unable to recall how the bruise occurred, there was no evidence that a more in-depth investigation was completed to determine the actual cause, nor was R39's injury of unknown origin reported to the state agency. R11's quarterly MDS, dated 4/15/15, indicated she was moderately, cognitively impaired. The CP, dated 6/3/15, indicated R11 required extensive to total assist for all ADLs, and was at risk for abuse related to depression. A review of SSIRF dated 10/21/15, indicated R39 had a bruise to the top of her right hand, dark purple in color, and measured 8 cm x 8 cm. The SSIRF indicated R11 was unable to state how the injury occurred, but R11 used anticoagulant medication, and R11's bruise was described as "minor." The facility administrator was notified but no report was made to the state agency. A second SSIRF, dated 11/4/14, indicated R11 had bruising noted to her left temple and above her left eyebrow. The SSIRF indicated R11 was unable to state the cause of the injury. The facility administrator was notified, but the injury was not reported to the state agency. A third SSIRF dated 12/18/14, indicated R11 had a bruise of unknown origin to her left inner knee, dark purple in color, and measuring 1 x 1 3/4 inches. The SSIRF indicated the injury was "unknown", that R11 was unable to report the cause of the injury, used anticoagulants; and also indicated the injury was considered to be "minor." The facility administrator was notified, but the injury was not reported to the state agency.	22000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00374	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

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22000	Continued From page 64 During an interview about the three injuries of unknown origin on 7/24/15, at 12:54 p.m., the SW stated, R11 "had more bruising than anyone I have ever known." The SW said the bruise on R11's hand "may have been caused by recent trimming of [R11's] nails," indicating R11 caused the bruise herself. Regarding the bruise noted to R11's temple and forehead, the SW stated that nursing felt the bruising "was due to placement of [R11's] nebulizer mask," however, the SW stated, she interviewed R11 who reported that she slipped and fell on her way back from supper. SW further stated R11 did not ambulate, used a Hoyer lift [a mechanical lift] for transferring, and there were no records of any falls. SW added the bruising was "likely due to placement of [R11's] nebulizer mask." No further investigation was completed for this injury. During an interview on 7/24/15, at 12:54 p.m., the DON stated R11 "could reliably answer" when the reporting nurse asked if bruising was related to abuse, therefore, the DON felt the injury was not reportable. Although R11 was identified to be moderately cognitively impaired, and had multiple bruises at different locations, there was no indepth investigation completed to determine the actual causes of R11's bruises. The facility administrator was notified of the injuries but none of these incidents were submitted to the state agency. R66's quarterly MDS, dated 1/7/15, indicated she was moderately, cognitively impaired. The CP, dated 2/9/15, indicated R66 required extensive assist of two staff, with use of a mechanical lift, for transfers. The CP also indicated R66 was at	22000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00374	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
22000	Continued From page 65 risk for delirium and potential abuse, related to depression. A review of SSIRF dated 2/3/15, indicated during a review of R66's nursing progress note dated 1/26/2015, there was "presence of unknown bruises" on [R66] both arms, the size was identified as bruising "from hands to shoulder." The SSIRF also indicated R66 now wore sleeve/arm protectors. The SSIRF indicated this was an "unknown injury", that R66 was unable to state the cause, and that the injury was assessed to be "minor." The injury was reported to the facility administrator, but was not not reported to the state agency. During an interview on 7/24/15, at 12:54 p.m., the SW stated, the bruises were noted while the DON was reviewing R66's progress notes. The SW said she "spoke with nursing" and determined the bruising was assessed "to be a minor injury, and therefore not reportable to the state agency." During an interview on 7/24/15, at 12:54 p.m., the DON said R66 used a Hoyer lift (mechanical lift), and R66 did not always cooperate in lift, occasionally "flailing her arms." The DON further stated R66 was confused, and that it would be "hard to say if R66 would have been able to to talk about how the bruising occurred after any time had passed." Although R66 had bilateral bruising from her hands to her shoulders, the injury was unwitnessed and the resident was unable to identify what happened. The facility had not immediately reported the incident to the state agency nor was a thorough investigation completed to determine if R66 was "flailing her arms" while using the mechanical lift.	22000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00374	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

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22000	Continued From page 66	22000		

R44's annual MDS, dated 6/9/15, indicated she was severely cognitively impaired. The CP, dated 7/10/15, indicated R44 required extensive assist with ADLs, and was at risk for abuse, related to short term memory loss and impaired decision-making skills.

A review of SSIRF dated 6/15/15, indicated R44 had a purple bruise on her posterior (back side) forearm, measuring 6.3 cm x 7 cm, that was found during her bath. The SSIRF indicated this was an "unknown" injury, and R66 could not state the cause of injury. The injury was determined to be "minor". The facility administrator was notified, but the injury was not reported to the state agency.

During an interview on 7/24/15, at 12:54 p.m., the SW stated, "The injury was determined by nursing staff to be 'minor' and did not meet any suspicious criteria. The SW said she "did not see a need to report" to the state agency.

In an interview on 7/24/15, at 12:54 p.m., the DON stated, "[R44] would have been able to tell you if something happened, she could make her needs known."

Even though R44 was assessed to be severely cognitively impaired, had an injury of "unknown" origin, on the posterior of her arm. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00374	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
22000	Continued From page 67	22000		

R8's quarterly minimum data set (MDS) identified her to be severely cognitively impaired and requiring assist of two staff for activities of daily living. CP dated 5/15/15 indicated R8 required extensive assist for activities of daily living and was at risk for abuse related to diagnosis of dementia.

A review of SSIRF dated 8/18/14, indicated R8 had a bruise measuring 8.5cm in length between her thumb and forefinger from the base of her thumb to her wrist. The reporting nurse did the initial evaluation and determined the bruising resulted from R8 wringing her hands, and the wringing of her hands was witnessed by staff.

During an interview on 7/24/15, at 12:54 p.m., SW stated, the injury was not reportable due to staff witness of the potential cause. No further investigation of the injury was completed. The facility administrator was notified of the injury but a report was not made to the state agency. A Social Services Incident Referral form was requested for this injury but was not received.

Although R8 had severe cognitive impairment, and had a bruise 8.5cm between her thumb and forefinger from the base of her thumb to her wrist. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency.

During an interview on 7/24/15, at 12:54 p.m., SW stated, when making a determination of whether or not to report an injury to the state agency, she "refers to statutes, and uses a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00374	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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22000	Continued From page 68	22000		

decision tree." The SW also stated that she looks at whether a resident is able to explain the injury, or if someone else saw it, and if there was a history of other recent falls and/or injuries. The SW further stated, "If the nurses indicated minor injury or injury not suspicious in nature or location, it does not need to be reported."

During an interview on 7/24/15, at 12:54 p.m., the DON said, minor injuries are not reportable to the state agency. She further stated, there was "no criteria or policy" the facility has to identify and determine whether an injury was "minor" versus "major." The DON also stated she "would use the nurses judgement" when determining if an injury was minor or major, and that the RN in charge "followed up on the injuries." However, she stated there was no charting on the clinical record that would show evidence that follow-up had been completed.

REFERENCE CHECKS
The facility's Abuse Prevention Policy, revised 7/15, indicated as its purpose "...to protect adults who are vulnerable to abuse..." Further, the policy included: "To assure the facility was doing everything within its control to prevent the occurrence of abuse or neglect...the facility would attempt to obtain information from previous employers and or/current employers."

NA-A's personnel record identified they were hired on 7/13/15. The personnel record lacked evidence reference checks were completed prior to employment at the facility.

NA-B's personnel record identified they were hired on 6/30/15. The personnel record lacked evidence reference checks were completed prior to employment at the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00374	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
22000	Continued From page 69 Dietary Aide (DA)-A's personnel record identified they were hired on 6/23/15. The personnel record lacked evidence reference checks were completed prior to employment at the facility. Registered nurse (RN)-B's personnel record identified they were hired on 5/11/15. The personnel record lacked evidence reference checks were completed prior to employment at the facility. On 7/23/15, at 8:45 a.m. human resources (HR) staff stated four of the five newly hired employees did not have documentation of reference checks. HR stated there was "not a process" to document that reference checks had been completed. They facility used the application references "to inquire about the position held, date of hire, eligibility for rehire and any feedback." SUGGESTED METHOD OF CORRECTION: The Administrator and/or designee could review and inservice facility staff to their policy in regard to abuse and neglect TIME PERIOD FOR CORRECTION: Fourteen (14) days.	22000		

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MDH

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Please print this page and give it to your state survey team. A page for both the CMS-671 and CMS-672 will be required to complete the process.	Print this Page
Would you like to go to the CMS-672 form for data entry?	Go to CMS-672
I'm finished and would like to exit the application.	Exit

Standard Survey Date Format: mm/dd/yy From F1: **07/20/15** To F2: **07/23/15**	Extended Survey Date Format: mm/dd/yy From F3: **07/24/15** To F4: **07/27/15**	
Name of Facility: **MILLE LACS HEALTH SYSTEM**	Provider Number: **245127**	Fiscal Year ending:
Address: **200 NORTH ELM STREET, ONAMIA, MILLE LACS, MN 56359**		
Telephone Number: F6 **320-532-2585**	State/County Code: **MN / MILLE LACS**	State/Region Code: **MN / 05**
A. F9 **03 - SNF/NF - Medicare/Medicaid** B. Is this facility hospital based? F10 **Yes** If yes, indicate Hopsital Provider Number: F11 **241356**		
Ownership: F12 **05 - Non Profit - Nonprofit Corporation**		
Owned or leased by Multi-Facility Organization: F13 **No** Name of Multi-Facility Organization: F14		
Dedicated Special Care Units (show number of beds for all that apply)		
AIDS F15 **0** Dialysis F17 **0** Head Trama F19 **0** Huntington's Disease F21 **0** Other Spec Rehab. F23 **0**	Alzheimer's Disease F16 **0** Disabled Child Young Adult F18 **0** Hospice F20 **0** Ventilator/Respiratory Care F22 **0**	
Does the facility currently have an organized resident group? F24		**Yes**
Does the facility currently have an organized group of family members of residents? F25		**Yes**
Does the facility conduct experimental research? F26		**No**

Is the facility part of a continuing care retirement community (CCRC)? F27	**No**

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of the last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement.	Date: mm/dd/yy F28 **NA**	Hours waived per week: F29 **NA**
Waiver of 24 hr licensed nursing requirement.	Date: mm/dd/yy F30 **NA**	Hours waived per week: F31 **NA**

Does the facility currently have an approved nurse aide training and competency program? F32	**Yes**

The following three questions are to be completed by the survey team.

1) Was this a staggered Survey?	**No - Not Staggered**
2) If staggered, day of the week starting?	**Surveyor to Complete**
3) If staggered, starting time?	**Surveyor to complete AM**

FACILITY STAFFING

		A	B	C	D
	Tag #	Services Provided 1 2 3	Full-Time Staff (hours)	Part-Time Staff (hours)	Contract (hours)
Administration	F33		**160**	**20**	**0**
Physician Services	F34	**Yes No Yes**			
Medical Director	F35		**0**	**8**	**0**
Other Physician	F36		**80**	**0**	**0**
Physician Extender	F37	**No No Yes**	**0**	**0**	**0**
Nursing Services	F38	**Yes No No**			
RN Director of Nursing	F39		**80**	**0**	**0**
Nurses with Admin Duties	F40		**160**	**40**	**0**
Registered Nurses	F41		**0**	**144**	**0**
Licensed Practical/ Vocational Nurses	F42		**80**	**480**	**8**
Certified Nurse Aides	F43		**480**	**1,168**	**0**
Nurse Aides in Training	F44		**0**	**0**	**0**

Medication	F45		0	96	0
Pharmacists	F46	Yes No No	0	0	8
Dietary Services	F47	Yes No No			
Dietitian	F48		0	40	0
Food Service Workers	F49		320	120	0
Therapeutic Services	F50				
Occupational Therapist	F51	Yes No Yes	0	24	0
Occupational Therapy Assistant	F52		0	16	0
Occupational Therapy Aides	F53		0	0	0
Physical Therapist	F54	Yes No Yes	0	40	0
Physical Therapy Assist	F55		0	0	0
Physical Therapy Aides	F56		0	20	0
Speech/Language	F57	Yes No Yes	0	8	0
Therapeutic Recreation Spec.	F58	No No No	0	0	0
Qualified Activities Prof.	F59	Yes No No	80	0	0
Other Activities Staff	F60	Yes No No	80	182	0
Qualified Social Workers	F61	Yes No No	80	0	0
Other Social Services Staff	F62	No No No	0	0	0
Dentists	F63	Yes No No	0	0	0
Podiatrists	F64	Yes No No	0	0	0
Mental Health Services	F65	Yes No Yes	0	0	0
Vocational Services	F66	No No No			
Clinical Laboratory Services	F67	Yes No Yes			
Diagnostic X-ray Services	F68	No No Yes			
Administration Storage of Blood	F69	No No Yes			

Housekeeping Services	F70	Yes No No	**204**	**360**	**0**
Other	F71		**160**	**64**	**0**
Name of Person Completing Form: **Kathleen Smude, RN DON**					Date: **07/28/15**

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MINNESOTA MDH DEPARTMENT of HEALTH

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Please print this page and give it to your state survey team. A page for both the CMS-671 and CMS-672 will be required to complete the process.	Print this Page
Would you like to go to the CMS-671 form for data entry?	Go to CMS-671
I'm finished and would like to exit the application.	Exit

MILLE LACS HEALTH SYSTEM				
Provider No. **245127**	Medicare F75 **2**	Medicaid F76 **27**	Other F77 **21**	Total Residents F78 **50**

ADL	Independent	Assist of One Two Staff	Dependent
Bathing	F79 **0**	F80 **43**	F81 **7**
Dressing	F82 **1**	F83 **40**	F84 **9**
Transferring	F85 **7**	F86 **37**	F87 **6**
Toilet Use	F88 **3**	F89 **41**	F90 **6**
Eating	F91 **26**	F92 **21**	F93 **3**

A. Bowel/Bladder Status	**B. Mobility**
F94 **2** With indwelling or external catheter.	F100 **1** Bedfast all or most of time..
F95 Of total number of residents with catheters, **2** were present on admission.	F101 **37** In chair all or most of time.
F96 **28** Occasionally or frequently incontinent of bladder.	F102 **1** Independently ambulatory.
F97 **23** Occasionally or frequently incontinent of bowel.	F103 **26** Ambulation with assistance or assistive device.
F98 **0** On individually written bladder training program.	F104 **0** Physically restrained.

F99 **0** On individually written bowel training program.

F105 Of total number of residents with restrained, **0** were admitted with orders for restraints.

F106 **1** With contractures.

F107 Of total number of residents with contractures, **0** had contractures on admission.

C. Mental Status

F108 **0** With mental retardation.

F109 **0** With documentation signs and symptoms of depression.

F110 **0** With documentation psychiatric diagnosis (excluding dementias and depression).

F111 **0** Dementia: multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type.

F112 **0** With behavioral symptoms.

F113 **0** Of the total number of residents with behavioral symptoms, the total number receiving a behavior management prpgram.

F114 **0** Receiving health rehabilitative services for MI/MR.

D. Skin Integrity

F115 **2** With pressure sores (exclude stage I).

F116 **1** Of the total number of residents with pressure sores excluding stage I, how many residents had pressure sores on admission?

F117 **35** Receiving preventive skin care.

F118 **0** With rashes.

E. Special Care

F119 **0** Receiving hospice care benefit.

F120 **0** Receiving radiation therapy.

F121 **0** Receiving chemotherapy.

F122 **0** Receiving dialysis.

F123 **0** Receiving intravenous therapy, parenteral nutrition, and/or blood transfusion.

F124 **7** Receiving respiratory treatment.

F125 **0** Receiving tracheostomy care.

F127 **0** Receiving suction.

F128 **5** Receiving injections (exclude vitamin B12 injections)

F129 **0** Receiving tube feedings.

F130 **9** Receiving mechanically altered diets including pureed and all chopped food (not only meat).

F131 **5** Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy).

F132 **4** Assistive devices while eating.

F126 **0** Receiving ostomy care.	

F. Medication	**G. Other**
F133 **21** Receiving any psychoactive medication.	F140 **2** With unplanned significant weight loss/gain.
F134 **3** Receiving antipsychotic medications.	F141 **0** Who do not communicate in the dominant language of the facility (includes those who use sign language).
F135 **2** Receiving antianxiety medications.	F142 **0** Who use non-oral communicationdevices.
F136 **16** Receiving antidepressant medications.	F143 **29** With advance directives.
F137 **1** Receiving hypnotic medication.	F144 **46** Received influenza immunization.
F138 **1** Receiving antibiotics.	F145 **45** Received pneumococcal vaccine.
F139 **33** On pain management program.	

I certify that this Information is accurate to the best of my knowledge.		
Name of Person Completing	Title	Date
Kathleen Smude	**RN., DON**	**07/28/2015**

To be completed by MDH survey team.
F146 Was ombudsman office notified prior to survey? **Yes**
F147 Was ombudsman present during any portion of the survey? **Yes**
F148 Medication error rate **0%**

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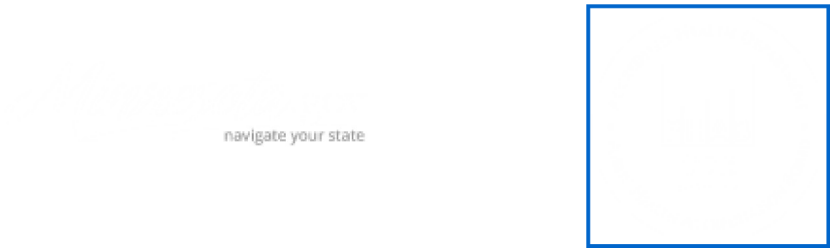

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245127	MILLE LACS HEALTH SYSTEM

Type of Survey (select all that apply):

I	K				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

B					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 20794	07-27-2015	07-27-2015	0.00	0.00	7.00	0.00	2.00	2.00
2. 28598	07-27-2015	07-27-2015	0.25	0.00	6.00	0.00	2.00	24.00
3. 29625	07-20-2015	07-23-2015	0.50	1.25	24.75	2.25	5.00	2.50
4. Team Leader 32613	07-20-2015	07-27-2015	1.00	4.25	42.50	2.50	4.00	37.25
5. 34987	07-20-2015	07-21-2015	0.25	0.00	11.75	2.25	2.00	0.00
6. 35569	07-20-2015	07-27-2015	0.00	4.25	36.00	9.00	4.00	29.25
7. 35992	07-20-2015	07-24-2015	0.00	4.25	36.50	2.50	2.00	0.00
8.								
9.								
10.								

Total Supervisory Review Hours	12.50
Total Clerical/Data Entry Hours.....	3.25
Was Statement of Deficiencies given to the provider on-site at completion of the survey?	Y

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245127	MILLE LACS HEALTH SYSTEM

Type of Survey (select all that apply):

H	K	I			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 03005	07-22-2015	07-22-2015	1.00	0.00	3.00	0.00	4.00	1.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.50

Total Clerical/Data Entry Hours..... 0.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? .....

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1 245127	**MILLE LACS HEALTH SYSTEM**	*K4 **07/22/2015**

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 1

NUMBER OF THIS BUILDING 01

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786 R	2000 EXISTING
13	2786 R	2000 NEW

ASC Form		
14	2786 U	2000 EXISTING
15	2786 U	2000 NEW

ICF/MR Form		
16	2786 V, W, X	2000 EXISTING
17	2786 V, W, X	2000 NEW

*K7 [12] SELECT NUMBER OF FORM USED FROM ABOVE

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)

K29: [ ] K56: [ ]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]

1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]

4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]

7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

*K9 : FACILITY MEETS LSC BASED ON: (*Check all that apply*)

A1 [X]	A2 [ ]	A3 [ ]	A4 [ ]	A5 [ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC:

B. [ ]

K180:

A. [X]	B. [ ]	C. [ ]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY

Project No: F5127023

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

2000 CODE

Form Approved
OMB No. 0938-0242

FIRE SAFETY SURVEY REPORT 2000 CODE - HEALTH CARE
Medicare – Medicaid

1. (A) PROVIDER NUMBER	1. (B) MEDICAID I.D. NO.
K1 245127	K2

PART I — Life & Safety Code, New and Existing
PART IV — Waiver Recommendation Form

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)	
Mille Lacs Hospital and Home C & NC	A. BUILDING X B. WING C. FLOOR K3	200 Elm St. Onamia, MN 56359	A (●) Fully Sprinklered (All required areas are sprinklered) B ( ) Partially Sprinklered (Not all required areas are sprinklered) C ( ) None (No sprinkler system) K0180

3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APPROVAL	SURVEY UNDER
[✓] MEDICARE [✓] MEDICAID	K4 7-22-2015	K6	5. (●) 2000 EXISTING 6. [ ] 2000 NEW K7

5. SURVEY FOR CERTIFICATION OF
1. ( ) HOSPITAL 2. (●) SKILLED/NURSING FACILITY 4. ( ) ICF/MR UNDER HEALTH CARE 5. ( ) HOSPICE

IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW
1. (●) ENTIRE FACILITY 2. ( ) DISTINCT PART OF (SPECIFY)_____

3. [ ] IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED BY JCAHO/AOA? a. ( ) YES b. ( ) NO

6. BED COMPOSITION				
a. TOTAL NO. OF BEDS IN THE FACILITY 57	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE 0	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE 57	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID 57	e. NUMBER OF NF or ICF/MR BEDS CERTIFIED FOR MEDICAID 0

7. A. (●) THE FACILITY MEETS, BASED UPON (CHECK ALL APPROPRIATE BOXES)
1. (●) COMPLIANCE WITH ALL PROVISIONS 2. ( ) ACCEPTANCE OF A PLAN OF CORRECTION 3. ( ) RECOMMENDED WAIVERS 4. ( ) LSES 5. ( ) PERFORMANCE BASED DESIGN
B. ( ) THE FACILITY DOES NOT MEET THE STANDARD
K9

SURVEYOR (Signature)	TITLE	OFFICE	DATE
SURVEYOR ID K10 Jeff Juntunen 0605	Deputy State Fire Marshal	State Fire Marshal	07/22/2015
FIRE AUTHORITY OFFICIAL (Signature)	TITLE	OFFICE	DATE
	Fire Safety Supervisor	State Fire Marshal	7-24-15

ID PREFIX		MET	NOT MET	N/A	REMARKS
	PART I - LSC REQUIREMENTS - Items in italics relate to the FSES				
	BUILDING CONSTRUCTION				
K11	If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2, 19.1.1.4.1, 19.1.1.4.2	○	○	◉	
K12	2000 EXISTING Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1	◉	○	○	K 12 Mille Lacs Health Center is a 1-story building with no basement. The original building was constructed in 1961 with an addition constructed in 1971. The 1961 building is of type II(111) construction and the 1971 building is type II (111) construction. Therefore, the nursing home was inspected as one building. From 2002-2004 the facility under went a complete renovation. A hospital, properly separated, is connected to the nursing home. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 57 beds and had a census of 50 at the time of the survey.
	1 ○ I (443), I (332), II (222) — Any Height				
	2 ○ II (111) — One story only (non-sprinklered).				
	3 ○ II (111) — Not over three stories with complete automatic sprinkler system.				
	4 ○ III (211) — Not over two stories with complete automatic sprinkler system.				
	5 ◉ V (111) — Not over two stories with complete automatic sprinkler system.				
	6 ○ IV (2HH) — Not over two stories with complete automatic sprinkler system.				
	7 ○ II (000) — Not over two stories with complete automatic sprinkler system.				
	8 ○ III (200) — Not over one story with complete automatic sprinkler system.				
	9 ○ V (000) — Not over one story with complete automatic sprinkler system.				
	☐ Building contains fire treated wood. *Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.*	○	○	◉	

ID PREFIX					MET	NOT MET	N/A	REMARKS
K12	2000 NEW Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.2.5.1							
	1		I (443), I (332), II (222)	Any height with complete automatic sprinkler system				
	2		II (111)	Not over three stories with complete automatic sprinkler system				
	3		III (211)	Not over one story with complete automatic sprinkler system.				
	4		V (111)					
	5		IV (2HH)					
	6		II (000)					
	7		III (200)	Not Permitted				
	8		V (000)					
	☐ Building contains fire treated wood. *Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.*							
K103	Interior walls and partitions in buildings of Type I or Type II construction shall be noncombustible or limited-combustible materials. 18.1.6.3, 19.1.6.3 (Indicate N/A for existing buildings using listed fire retardant treated wood studs within non-load bearing one-hour rated partitions.)				○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	INTERIOR FINISH				
K14	2000 EXISTING Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2 *Indicate flame spread rating/s* < 200	◉	○		
	2000 NEW Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Lower portion of corridor walls can be Class C. 18.3.3.1, 18.3.3.2 *Indicate flame spread rating/s*_____				
K15	2000 EXISTING Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2 *Indicate flame spread rating/s* <25	◉	○		
	2000 NEW Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (Rooms not over 4 persons in capacity may have a flame spread rating of Class A, Class B, or Class C). 18.3.3.1, 18.3.3.2. *Indicate flame spread rating/s*_____				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K16	Newly installed interior floor finish complying with 10.2.7 shall be permitted in corridors and exits if Class I. 18.3.3.3, 19.3.3.3 (Indicate N/A for existing interior floor finish.) In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, no interior floor finish requirements shall apply.	○	○	◉	
	CORRIDOR WALLS AND DOORS				
K17	2000 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 *If the walls have a fire resistance rating, give rating* 1 hour *if the walls terminate at the underside of a ceiling, give a brief description in REMARKS, of the ceiling, describing the ceiling throughout the floor area.*	◉	○		
	2000 NEW Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.5				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K18	2000 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1 3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	◉	○		
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
	2000 New Doors protecting corridor openings shall be constructed to resist the passage of smoke. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3				
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
K19	Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5, 18.3.6.3.1, 19.3.6.2.3, 19.3.6.3.8, 19.3.6.5	◉	○	○	
K22	Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4	◉	○	○	
	VERTICAL OPENINGS				
K20	2000 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6, 19.3.1.1	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box. ☐	○	○	◉	
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
	2000 NEW Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least two hours connecting four stories or more. (One hour for single story building and sprinklered buildings up to three stories in height.) 18.3.1.1. An atrium may be used in accordance with 8.2.2.3.5.				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
K21	Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure shall be permitted to be held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: ☑ (a) The required manual fire alarm system and ☑ (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and ☑ (c) The automatic sprinkler system, if installed 18.2.2.2.6, 19.2.2.2.6, 7.2.1.8.2	◉	○	○	
	Describe method used in REMARKS				
K33	2000 EXISTING Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box. ☐	○	○	◉	
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
	2000 NEW Exit components (such as stairways) in buildings four stories or more are enclosed with construction having a fire resistance rating of at least two hours, are arranged to provide a continuous path of escape, and provide a protection against fire and smoke from other parts of the building. In all buildings less than four stories, the enclosure is at least one hour. 8.2.5.4, 18.3.1.1				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
	SMOKE COMPARTMENTATION AND CONTROL				
K23	2000 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping room floor for more than 30 patients. 19.3.7.1, 19.3.7.2	◉	○	○	
	2000 NEW Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Smoke barriers shall also be provided on floors that are usable, but unoccupied. 18.3.7.1, 18.3.7.2				
K24	The smoke compartments shall not exceed 22,500 square feet and the travel distance to and from any point to reach a door in the required smoke barrier shall not exceed 200 feet. 18.3.7.1, 19.3.7.1	◉	○	○	
	Detail in REMARKS zone dimensions including length of zones and dead end corridors.				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K25	2000 EXISTING Smoke barriers shall be constructed to provide at least a one-half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments shall be provided on each floor. Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems.19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	◉	○	○	
	2000 NEW Smoke barriers shall be constructed to provide at least a one-hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments shall be provided on each floor. Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3				
K26	Space shall be provided on each side of smoke barriers to adequately accommodate those occupants served. 18.3.7.4, 19.3.7.4	◉	○	○	
K27	2000 EXISTING Door openings in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7	◉	○	○	
	2000 NEW Door openings in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K28	2000 EXISTING Door openings in smoke barriers shall provide a minimum clear width of 32 inches (81 cm) for swinging or horizontal doors. Vision panels are of fire-rated glazing or wired glass panels and steel frames. 19.3.7.5, 19.3.7.7	◉	○	○	
	2000 NEW Door openings in smoke barriers are installed as swinging or horizontal doors shall provide a minimum clear width as follows: Provider Type / Swinging Doors / Horizontal Sliding Doors Hospitals and Nursing Facilities: 41.5 inches (105 cm) / 83 inches (211 cm) Psychiatric Hospitals and Limited Care Facilities: 32 inches (81 cm) / 64 inches (163 cm) Vision panels of fire-rated glazing or wired panels in approved frames are provided for each door. 18.3.7.5, 18.3.7.7				
K104	Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.	◉	○	○	
	Describe any mechanical smoke control system in REMARKS.				
	HAZARDOUS AREA				
K29	2000 EXISTING One hour fire rated construction (with 3/4 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	◉	○	○	

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms			✔
c. Laundries (greater than 100 sq feet)			✔
d. Repair Shops and Paint Shops			✔
e. Laboratories (if classified a Severe Hazard - see K31)			✔
f. Combustible Storage Rooms/Spaces (over 50 sq feet)	✔	✔	
g. Trash Collection Rooms			✔
i. Soiled Linen Rooms	✔	✔	

Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1				

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms			
c. Laundries (greater than 100 sq feet)			
d. Repair, Maintenance and Paint Shops			
e. Laboratories (if classified a Severe Hazard - see K31)			
f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq feet)			
g. Trash Collection Rooms			
i. Soiled Linen Rooms			
m.Combustible Storage Rooms/Spaces (over 100 sq feet)			

Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.

K30	Gift shops shall be protected as hazardous areas when used for storage or display of combustibles in quantities considered hazardous. Non-rated walls may separate gift shops that are not considered hazardous, have separate protected storage and that are completely sprinkled. Gift shops may be open to the corridor if they are not considered hazardous, have separate protected storage, are completely sprinklered and do not exceed 500 square ºfeet. 18.3.2.5, 19.3.2.5	○	○	◉	

Area	Automatic Sprinkler	Separation	N/A
L. Gift Shop storing hazardous quantities of combustibles	☐	☐	☐

K211	2000 EXISTING Where Alcohol Based Hand Rub (ABHR) dispensers are installed: ☑ The corridor is at least 6 feet wide ☑ The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) ☑ The dispensers shall have a minimum spacing of 4 ft from each other ☑ Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. ☑ Dispensers are not installed over or adjacent to an ignition source. ☑ If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K211	2000 NEW Where Alcohol Based Hand Rub (ABHR) dispensers are installed: ❏ The corridor is at least 6 feet wide ❏ The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) ❏ The dispensers shall have a minimum spacing of 4 ft from each other ❏ Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. ❏ Dispensers are not installed over or adjacent to an ignition source. ❏ If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623				
	EXIT AND EXIT ACCESS				
K32	Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2	◉	○		
	EXITS AND EGRESS				
K34	Stairways and smokeproof towers used as exits are in accordance with 7.2. 18.2.2.4, 19.2.2.3, 19.2.2.4	◉	○	○	
K35	Capacity of exits in number of persons per unit of exit width is in accordance with 7.3. 18.2.3.1, 19.2.3.1	◉	○		
K36	Travel distance (exit access) to exits are in accordance with 7.6. 18.2.6, 19.2.6	◉	○		
K37	2000 EXISTING Existing dead-end corridors shall be permitted to be continued to be used if it is impractical and unfeasible to alter them so that exists are accessible in not less than two different directions from all points in aisles, passageways, and corridors. 19.2.5.10	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW Every exit and exit access shall be arranged so that no corridor, aisle or passageway has a pocket or dead-end exceeding 30 feet. 18.2.5.10				
K38	Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1	◉	○		
K39	2000 EXISTING Width of aisles or corridors (clear and unobstructed) serving as exit access shall be at least 4 feet. 19.2.3.3	◉	○		
	2000 NEW Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet. 18.2.3.3, 18.2.3.4				
K40	2000 EXISTING Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. 19.2.3.5	◉	○		
	2000 NEW Exit access doors and exit doors used by health care occupants are of the swinging type, with openings of at least 41.5 inches wide. Doors in exit stairway enclosures shall be no less than 32 inches in clear width. In ICFs/MR, doors are at least 32 inches wide. 18.2.3.5				
K41	All sleeping rooms have a door leading to a corridor providing access to an exit or have a door leading directly to grade. One room may intervene in accordance with 18.2.5.1, 19.2.5.1, 18.2.5.9, 19.2.5.9 *If doors lead directly to grade from each room, check this box.* ☐	◉	○		
K42	Any room or suite of rooms of more than 1,000 sq. ft. has at least 2 exit access doors remote from each other. 18.2.5.2, 19.2.5.2	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K43	Patient room doors are arranged such that the patients can open the door from inside without using a key.	◉	○		
	Special door locking arrangements are permitted in facilities. 18.2.2.2.4, 18.2.2.2.5 *If door locking arrangement without delay egress is used indicate in REMARKS* 18.2.2.2.2, 19.2.2.2.2	○	○		
K44	Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5, 19.2.2.5	◉	○	○	
	ILLUMINATION AND EMERGENCY POWER				
K45	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. 18.2.8, 19.2.8, 7.8	◉	○	○	
K46	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 18.2.9.1, 19.2.9.1.	◉	○	○	
K47	2000 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one story buildings with less than 30 occupants where the line of exit travel is obvious.)	◉	○	○	
	2000 NEW Exit and directional signs are displayed with continuous illumination also served by the emergency lighting, system in accordance with 7.10. 18.2.10.1				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K105	2000 NEW (INDICATE N/A FOR EXISTING) Buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the Life Safety Branch of the electrical system described in NFPA 99. 18.2.9.2., 18.2.10.2, 18.5.1.1, 18.5.1.2 (Indicate N/A if life support equipment is for emergency purposes only).	○	○	○	
K107	2000 NEW (INDICATE N/A FOR EXISTING) Required alarm and detection systems are provided with an alternative power supply in accordance with NFPA 72. 9.6.1, 18.3.4.1.3	○	○	○	
K108	2000 NEW (INDICATE N/A FOR EXISTING) Alarms, emergency communication systems, and illumination of generator set locations are in accordance with NFPA 70. 9.1.2	○	○	○	
	EMERGENCY PLAN AND FIRE DRILLS				
K48	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1, 19.7.1.1	◉	○		
K50	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2	◉	○		

ID PREFIX		MET	NOT MET	N/A	REMARKS
	FIRE ALARM SYSTEMS				
K51	2000 EXISTING A fire alarm system with approved component, devices or equipment installed according to NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system shall be by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas, may be omitted provided that manual pull stations are within 200 ft of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests shall be available. A reliable second source of power must be provided. Fire alarm systems shall be in accordance with NFPA72, and records of maintenance kept readily available. There shall be annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	◉	○		
	2000 NEW A fire alarm system with approved component, devices or equipment installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system shall be by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests shall be available. A reliable second source of power must be provided. Fire alarm systems shall be maintained in accordance with NFPA72, and records of maintenance kept readily available. There shall be remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6				
K52	A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4	◉	○		
K155	Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K53	2000 EXISTING (INDICATE N/A FOR HOSPITAL AND FULLY SPRINKLERED NURSING HOMES) In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. CFR 483.70	○	○	◉	
	2000 NEW (NURSING HOME AND EXISTING LIMITED CARE FACILITIES) An automatic smoke detection system is installed in all corridors. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridor.) Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.3				
K109	2000 EXISTING LIMITED CARE FACILITIES (INDICATE N/A FOR HOSPITALS OR NURSING HOMES) An automatic smoke detection system is installed in all corridors with detector spacing no further apart than 30 ft on center in accordance with NFPA 72. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridors.) Such detectors are electrically interconnected to the fire alarm system. 19.3.4.5.1 Smoke Detection System ☐ Corridors ☐ Rooms ☐ Bath	○	○	◉	
K54	All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3	◉	○	○	
	Give a brief description, in REMARKS of any smoke detection system which may be installed.	○			

ID PREFIX		MET	NOT MET	N/A	REMARKS
K55	2000 EXISTING Every patient sleeping room shall have an outside window or outside door. Except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8	◉	○	○	
	2000 NEW Every patient sleeping room shall have an outside window or outside door. The allowable sill height shall not exceed 36 inches (91 cm) above the floor. Windows are not required for recovery rooms, newborn nurseries, emergency rooms, and similar rooms intended for occupancy for less than 24 hours. Window sill height for limited care facilities shall not exceed 44 inches (112 cm) above the floor. 18.3.8				
	AUTOMATIC SPRINKLER SYSTEMS				
K56	2000 EXISTING Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. 19.3.5, NPFA 13	◉	○	○	
	2000 NEW There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. 18.3.5.				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K154	Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1.	◉	○	○	
	A. Date sprinkler system last checked and necessary maintenance provided. 6-12-15	◉	○		
	B. Show who provided the service. Simplex	◉	○		
	C. Note the source of water supply for the automatic sprinkler system. City Water with FDC	◉	○		
	(Provide, in REMARKS, information on coverage for any non-required or partial automatic sprinkler system.)	○			
K60	Initiation of the required fire alarm systems shall be by manual means in accordance with 9.6.2 and by means of any required sprinkler system waterflow alarms, detection devices, or detection systems. 18.3.4.2, 19.3.4.2, 9.6.2.1	◉	○	○	
K61	Required automatic sprinkler systems shall have valves supervised so that at least a local alarm will sound when the valves are closed. 9.7.2.1, NFPA 72	◉	○	○	
K62	Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	◉	○	○	
K63	Required automatic sprinkler systems have an adequate and reliable water supply which provides continuous and automatic pressure. 9.7.1.1, NFPA 13	◉	○	○	
K64	Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6	◉	○		

ID PREFIX		MET	NOT MET	N/A	REMARKS
	SMOKING REGULATIONS				K 66 Smoke Free
K66	Smoking regulations shall be adopted and shall include not less than the following provisions: 18.7.4, 19.7.4 (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) Smoking by patients classified as not responsible shall be prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	◉	○		
	BUILDING SERVICE EQUIPMENT				
K67	Heating, ventilating, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2, NFPA 90A, 18.5.2.2, 19.5.2.2	◉	○	○	
K68	Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 18.5.2.2, 19.5.2.2.	◉	○	○	
K69	Cooking facilities shall be protected in accordance with 9.2.3. 18.3.2.6, 19.3.2.6, NFPA 96	◉	○	○	
K70	Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). 18.7.8, 19.7.8	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K71	Rubbish Chutes, Incinerators and Laundry Chutes. 18.5.4, 19.5.4, 9.5, 8.4, NFPA 82	○	○	◉	K 71 & 160 None
	☐ (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes shall comply with 9.5.				
	☐ (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7.				
	☐ (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4.				
	☐ (4) Existing flue-fed incinerators shall be sealed by fire resistive construction to prevent further use.				
K160	2000 EXISTING All existing elevators, having a travel distance of 25 ft or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* 19.5.3, 9.4.3.2	○	○	◉	
	ANSI A17.1 states 25 ft or more above or below the designated level and defines "designated level" as the main floor or other floor level that best serves the needs of emergency personnel for fire fighting purposes or rescue purposes identified by the building code or fire authority. Depending on floor slab thickness and heights this would generally apply to a three-story building, and almost certainly to a four-story building.				
	Includes firefighters service **phase I** key recall and smoke detector automatic recall, firefighters service **phase II** emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors. 19.5.3, 9.4.3.2				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K161	2000 EXISTING All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* 19.5.3, 9.4.2.2 Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.	○	○	◉	K 161 None
	2000 NEW All elevators, escalators, and conveyors comply with ASME/ ANSI A17.1, *Safety Code for Elevators and Escalators* (Includes car emergency signaling, firefighters service phase I key and smoke detector automatic recall, firefighters service phase II emergency in-car operation, machine room smoke detectors, elevator lobby smoke detectors). 18.5.3, 9.4				
	FURNISHINGS AND DECORATIONS				
K72	Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10	◉	○		
K73	No furnishings or decorations of highly flammable character shall be used. 18.7.5.2, 18.7.5.3, 18.7.5.4, 19.7.5.2, 19.7.5.3, 19.7.5.4	◉	○		
K74	Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies shall be in accordance with provisions of 10.3.1 and NFPA 13 Standard for the Installation of Sprinkler Systems. Except shower curtains shall be in accordance with NFPA 701. ☐ Newly introduced upholstered furniture shall meet the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.1. 18.3.5.3 and NFPA 13 ☐ Newly introduced mattresses shall meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3 Newly introduced upholstered furniture and mattresses means purchased since March, 2003.	◉	○		

ID PREFIX		MET	NOT MET	N/A	REMARKS
K75	Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed .5 gal/ft^2 (20.4 L/m^2). A capacity of 32 gal (121 L) shall not be exceeded within any 64-ft^2 (5.9-m^2) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. 18.7.5.5, 19.7.5.5	◉	○		
	LABORATORIES				
K31	Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard shall be protected in accordance with NFPA 99. (Laboratories that are not considered to be severe hazard shall meet the provision of K29.) Laboratories in Health Care occupancies and medical and dental offices shall be in accordance with NFPA 99, Standard for Health Care Facilities 10.5.1.	○	○	◉	K 31 Lab in attached hospital
K136	Procedures for laboratory emergencies shall be developed. Such procedures shall include alarm actuation, evacuation, and equipment shutdown procedures, and provisions for control of emergencies that could occur in the laboratory, including specific detailed plans for control operations by an emergency control group within the organization or a public fire department in accordance with NFPA 99, 10.2.1.3.1, 18.3.2.2., 19.3.2.1	○	○	◉	
K131	Emergency procedures shall be established for controlling chemical spills in accordance with NFPA 99. 10.2.1.3.2	○	○	◉	
K132	Continuing safety education and supervision shall be provided, incidents shall be reviewed monthly, and procedures reviewed annually shall be in accordance with NFPA 99. 10.2.1.4.2	○	○	◉	
K133	Fume hoods shall be in accordance with NFPA 99. 5.4.3, 5.6.2	○	○	◉	
K134	Emergency Shower: Where the eyes or body of any person can be exposed to injurious corrosive materials, suitable fixed facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use. Fixed eye baths designed and installed to avoid injurious water pressure shall be in accordance with NFPA 99, 10.6.	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K135	Flammable and combustible liquids shall be used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals. Storage cabinets for flammable and combustible liquids shall be constructed in accordance with NFPA 30, Flammable and Combustible liquids Code NFPA 99, 4.3, 10.7.2.1.	○	○	◉	
	MEDICAL GASES AND ANESTHETIZING AREAS				
K76	Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99, 4.3.1.1.2, 18.3.2.4, 19.3.2.4	◉	○	○	
K77	Piped in medical gas systems comply with NFPA 99, Chapter 4.	○	○	◉	
K78	Anesthetizing locations shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Shutoff valves are located outside each anesthetizing location and arranged so that shutting off one room or location will not affect others. (b) Relative humidity is maintained equal to or great than 35% NFPA 99 4.3.1.2.3(n) and 5.4.1.1, 18.3.2.3, 19.3.2.3	○	○	◉	K 77, 78, 140, 142, 143 None
K140	(a) Master alarm panels are in two separate locations and have audible and visible signals. (b) There are high/low alarms for +/- 20% operating pressure. This section shall be in accordance with NFPA 99, 4.3.1.2.2 (c) Where a level 2 gas system is used, one alarm panel that complies with 4.3.1.2.2(b) 3 a, b, c and d and with 4.3.1.2.2(c) 2 and 5 shall be permitted. (4.4.1 exception No. 4).	○	○	◉	
K141	Non-smoking and no smoking signs in areas where oxygen is used or stored shall be in accordance with 18.3.2.4, 19.3.2.4, NFPA 99, 8.6.4.2	◉	○		
K142	All occupancies containing hyperbaric facilities shall comply with NFPA 99, Standard for Health Care Facilities, Chapter 19.	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K143	Transferring of oxygen shall be: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association. 8.6.2.5.2	○	○	●	
	ELECTRICAL				
K106	The hospital and all nursing homes and hospices with life support equipment has a Type I Essential Electrical System powered by a generator with a transfer switch and separate power supply. The EES is in accordance with NFPA 99, 3.4.2.2, 3.4.2.1.4	○	○	●	The End, JCJ, DSFM
K144	Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99, 3.4.4.1, NFPA 110, 8.4.2	●	○	○	Meets LSC(00)
K145	The Type I EES is divided into the critical branch, life safety branch and the emergency system and shall be in accordance with NFPA 99, 3.4.2.2.2	○	○	●	
K146	The nursing home/hospice with no life support equipment shall have an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source NFPA 99, 3.6.	●	○	○	
K147	Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. 9.1.2	●	○		
K130	Miscellaneous List in the REMARKS sections, any items that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	●	○	○	

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84	

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1		* K4

K6 DATE OF PLAN APPROVAL

K3 MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS _____

NUMBER OF THIS BUILDING _____

☐

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786R	2000 EXISTING
13	2786R	2000 NEW

ASC Form		
14	2786U	2000 EXISTING
15	2786U	2000 NEW

ICF/MR Form		
16	2786V, W, X	2000 EXISTING
17	2786V, W, X	2000 NEW

* K7 ☐ SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: ☐ 1 PROMPT 2 SLOW 3 IMPRACTICAL

LARGE

K8: ☐ 4 PROMPT 5 SLOW 6 IMPRACTICAL

APARTMENT HOUSE

K8: ☐ 7 PROMPT 8 SLOW 9 IMPRACTICAL

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X and Y.)

K29: ☐ K56: ☐

ENTER E – SCORE HERE

K5: ☐ e.g. 2.5

*K9: FACILITY MEETS LSC BASED ON *(Check all that apply)*

A1. ☐ (COMP. WITH ALL PROVISIONS)

A2. ☐ (ACCEPTABLE POC)

A3. ☐ (WAIVERS)

A4. ☐ (FSES)

A5. ☐ (PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B. ☐

K0180

A. ☐ FULLY SPRINKLERED (All required areas are sprinklered)

B. ☐ PARTIALLY SPRINKLERED (Not all required areas are sprinklered)

C. ☐ NONE (No sprinkler system)

* MANDATORY

PROJECT NUMBER:	PROVIDER NAME	SURVEY DATE
F5127023	Mille Lacs Hospital and Home C & NC	7-22-15

Administrator: Sharon Falknor, Interm | Phone Number: (320) 532-3154

Email address: sfalknor@mlhealth.org

State Fire Inspector: Jeff Juntunen jeffrey.juntunen@state.mn.us or (651) 769-7776 (C)

These are preliminary findings only. A complete and final Statement of Deficiencies 2567 report will be provided by US Mail.

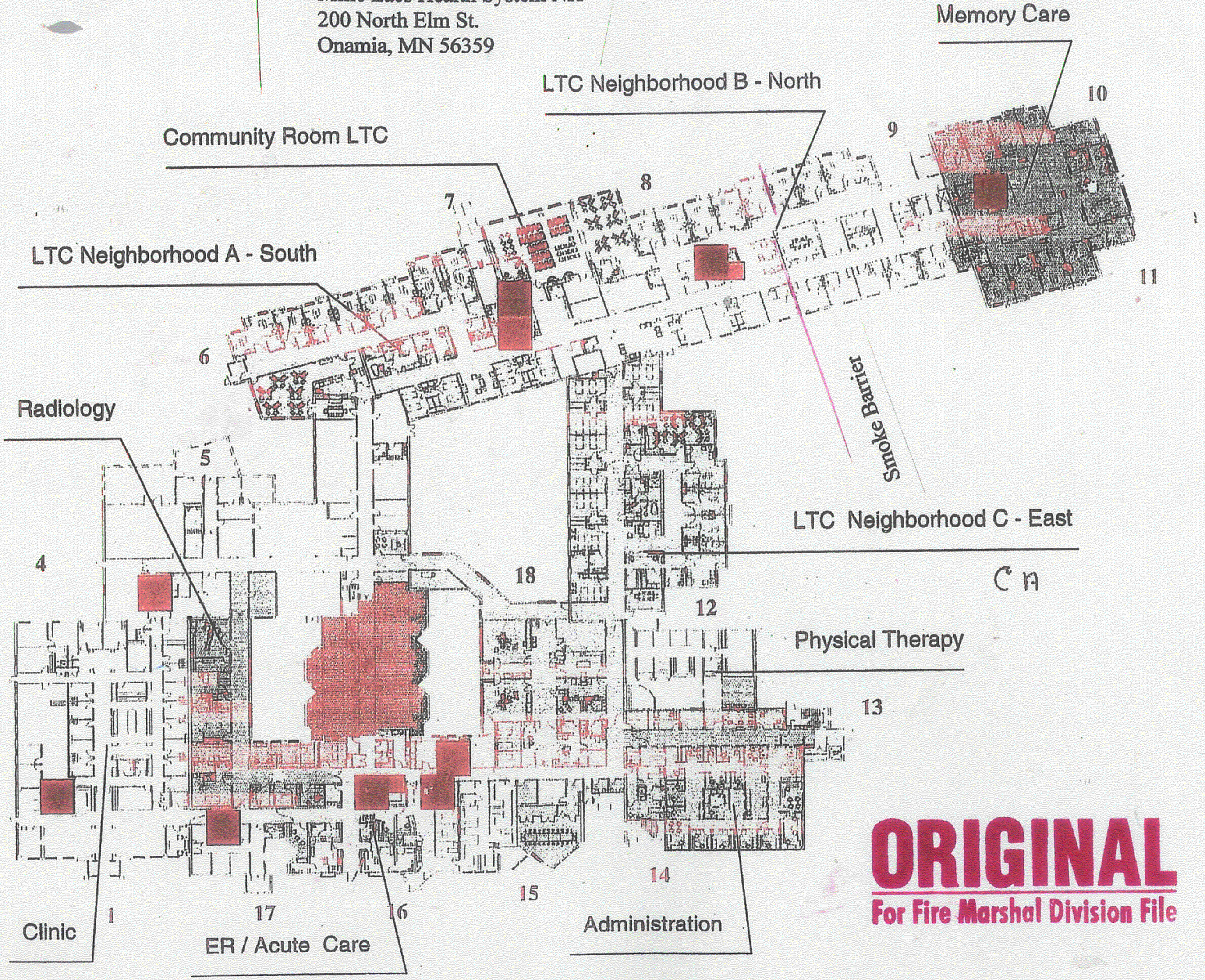
☑ **At the time of this inspection, this facility was found to comply with the requirements of the 2000 Life Safety Code applicable to:** ☑ **SNF/NF** ☐ **Hospital** ☐ **ICFMR** ☐ **ASC Facilities participating in the Medicare/Medicaid programs.**

☐ **The following fire/life safety deficiencies were found during this inspection:**

K TAG S& S	☑ **Draft Summary of Deficiency(ies)** ☐ **Revisit** ☐ **Clearance**
	This was an inspection for State License and Federal Certification. At this time, the facility meets LSC(00) Chapter 19 Existing Health Care. Data File: 43695

Mille Lacs Health System NH
200 North Elm St.
Onamia, MN 56359

File No HC 140592



C n

ORIGINAL
For Fire Marshal Division File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

September 4, 2015

Ranjita Adhikari, M.D.
Mille Lacs Health System
200 North Elm Street
Onamia, Minnesota 56359

Dear Dr. Ranjita Adhikari,

The Minnesota Department of Health, Health Regulation Division, is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard quality of care means one or more deficiencies related to participation requirements under 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

Based on our survey of:

Mille Lacs Health System
200 North Elm Street
Onamia, MN 56359,

which was completed on July 27, 2015, we have determined that substandard quality of care was provided. Listed below are the federal violations that led to this determination.

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The above facility has prepared a plan to correct the deficiencies which we found during the survey. You can assist by discussing the survey findings with the facility's medical director. Copies of the survey findings which provide detailed information on the violations can be reviewed at the facility or at the address below.

If you have any questions, please feel free to contact me.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

September 4, 2015

Roger Boettcher, M.D.
Mille Lacs Health System
200 North Elm Street
Onamia, Minnesota 56359

Dear Dr. Roger Boettcher:

The Minnesota Department of Health, Health Regulation Division, is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard quality of care means one or more deficiencies related to participation requirements under 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

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September 4, 2015

Thomas Bracken, M.D.
Mille Lacs Health System
200 North Elm Street
Onamia, Minnesota 56359

Dear Dr. Thomas Bracken:

The Minnesota Department of Health, Health Regulation Division, is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard quality of care means one or more deficiencies related to participation requirements under 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

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September 4, 2015

Cathy Donovan, M.D.
Mille Lacs Health System
200 North Elm Street
Onamia, Minnesota 56359

Dear Dr. Cathy Donovan:

The Minnesota Department of Health, Health Regulation Division, is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard quality of care means one or more deficiencies related to participation requirements under 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

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kate.johnston@state.mn.us
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MINNESOTA
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Protecting, Maintaining and Improving the Health of Minnesotans

September 4, 2015

Mohan Karki, M.D.
Mille Lacs Health System
200 North Elm Street
Onamia, Minnesota 56359

Dear Dr. Mohan Karki:

The Minnesota Department of Health, Health Regulation Division, is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard quality of care means one or more deficiencies related to participation requirements under 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

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kate.johnston@state.mn.us
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MINNESOTA
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Protecting, Maintaining and Improving the Health of Minnesotans

September 4, 2015

Lynne Steiner, M.D.
Mille Lacs Health System
200 North Elm Street
Onamia, Minnesota 56359

Dear Dr. Lynne Steiner:

The Minnesota Department of Health, Health Regulation Division, is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard quality of care means one or more deficiencies related to participation requirements under 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

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September 4, 2015

David Strobel, M.D.
Mille Lacs Health System
200 North Elm Street
Onamia, Minnesota 56359

Dear Dr. David Strobel:

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Protecting, Maintaining and Improving the Health of Minnesotans

September 4, 2015

Arden Virnig, M.D.
Mille Lacs Health System
200 North Elm Street
Onamia, Minnesota 56359

Dear Dr. Arden Virnig:

The Minnesota Department of Health, Health Regulation Division, is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard quality of care means one or more deficiencies related to participation requirements under 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

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MINNESOTA
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Protecting, Maintaining and Improving the Health of Minnesotans

September 4, 2015

Patty Hook-Virnig, M.D.
Mille Lacs Health System
200 North Elm Street
Onamia, Minnesota 56359

Dear Dr. Patty Hook-Virnig:

The Minnesota Department of Health, Health Regulation Division, is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard quality of care means one or more deficiencies related to participation requirements under 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

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Health Regulation Division
kate.johnston@state.mn.us
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Enclosure (s)
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S5127025

MINNESOTA DEPARTMENT OF HEALTH
Division of Health Policy, Information and Compliance Monitoring
85 East Seventh Place, Suite 300, P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email for ADMINISTRATOR: kkucera@mlhealth.org

National Provider Identifier (NPI) Number: 1356504864

One facility may have multiple NPI Numbers. Please verify the NPI number associated with the provider type for this survey, i.e. for a nursing home survey, the NPI Number will be associated with the Nursing Home.

OWNERSHIP INFORMATION AT THE TIME OF SURVEY

Name of Facility: MILLE LACS HEALTH SYSTEM City: ONAMIA

Name of Legal Entity Operating Provider: MILLE LACS HEALTH SYSTEM

Name and Address of Governing Board President:

Name: MARK TADYCH

Address: PO BOX 81

City/State/Zip: GARRISON, MN 56450

If legal entity or president of the governing board is different than what is noted above, please provide the information below.

Name of Facility: _____ City: _____

Name of Legal Entity Operating Provider: _____

Name and Address of Governing Board President:

Name: _____

Address: _____

City/State/Zip: _____

SIGNATURE

Completed by: Kyra Kucera

Title: LTC Administrator

Date: 7/20/15

MINNESOTA
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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 10, 2015

Ms. Kim Kucera, Administrator
Mille Lacs Health System
200 North Elm Street
Onamia, Minnesota 56359

RE: Project Number S5127025

Dear Ms. Kucera:

On July 23, 2015, an extended survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate

jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

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:

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
Health Regulation Division
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 5, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 5, 2015 the following remedy will be imposed:

- Per instance civil money penalty (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Mille Lacs Health System is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective July 27, 2015. 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.

APPEAL RIGHTS

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

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:

Jan.Suzuki@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 Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action

completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by October 23, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 23, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245127	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

(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 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An extended survey was conducted by the Minnesota Department of Health on 7/27/2015	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure safe self-administration of medications (SAM) for 1 of 1 residents (R63) observed for self-administration of a nebulizer treatment. Findings include: During observation on 7/20/15, at 7:28 p.m. R63 was observed alone in her room with a nebulizer (a drug delivery device used to administer medications in the form of a mist inhaled into the	F 176		

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

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lungs) running, with a face mask. The trained medication aide (TMA)-A who had administered the medication was on the opposite side of the dining room passing medications and assisting other residents in their rooms. R63 removed the mask off her nose and mouth and placed the mask on her chest with the elastic strap still around the back of her neck. TMA-A walked past R63's room while R63 had the mask on her chest and into the room next to R63 twice. TMA-A made no attempted to check, or reapply the mask to R63's nose and mouth for installation of the medication. At 7:44 p.m. TMA-A entered R63's room, turned off the nebulizer and removed the mask from R63's chest.

R63's diagnoses included dementia with behavioral disturbances, depression, anxiety, chronic obstructive pulmonary disease (COPD) and congestive heart failure. A cognition care plan dated 6/2/15, indicated R63 was disorientated to time and place and had moderately impaired cognition.

The Physician's Orders and the Medication Administration Record (MAR) for 7/15, directed Duoneb to be administered four times a day. A hand written note on the MAR indicated R63 did not like the nebulizer mask and to hold the mask in front of her face and let her breathe in that way.

A Self Administration of Medication Assessment effective 7/21/15, indicated R63 was not cognitively able to participate in a SAM.

During interview on 7/20/15, at 7:50 p.m. TMA-A stated she did not know if R63 could be left alone with the nebulizer. TMA-A added she usually does not leave residents alone with their

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F 176	Continued From page 2 nebulizer but because it had been so hectic and busy she left R63 alone. On 7/23/15, at 11:20 a.m. registered nurse (RN)-A stated R63 was assessed to not to be left alone to SAM the nebulizer. In the past she would not even allow the mask but now will allow staff to hold the mask in front of her.	F 176		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225		

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The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure all allegations of abuse, neglect, mistreatment and injuries of unknown were immediately reported to the adminstrator and state agency, were thoroughly investigated, and residents were protected during their investigations for 8 of 15 residents' (R47, R12, R22, R39, R11, R66, R44 and R8) allegations reviewed. The facility failed to conduct reference checks for 4 of 5 newly hired employees (NA-A, NA-B, DA-A and RN-B).

Findings include:

Investigation and Protection

During interview 7/23/15, at 5:09 p.m. with social worker (SW) stated that nursing assistant (NA)-C has been implicated in four incident reports from January 2015 to July 2015 as the potential alleged perpetrator (AP).

Review of facility Incident and Investigation reports indicated the following:

R47's quarterly Minimum Data Set (MDS) dated 2/17/15, indicated she was moderately cognitively

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intact and needed extensive assistance in ADLs. R47's care plan dated 2/26/15, indicated she had dementia and needs assist with dressing, grooming and bathing. The care plan further indicated she had slight alteration in cognition related to dementia and that resident will continue to be oriented to person, place and time.

Mille Lacs Nursing Home Progress Notes dated 1/24/15, at 3:49 a.m. indicated: "This nurse [LPN-D] was in a res. room, 5 rooms away from where the incident happened, but heard a distinct smack. Followed by a woman's out cry. This nurse then got a call on the walkie [walkie-talkie] from the aide. The aide stated (in her words) On 2 a.m. rounds, I went to check resident in room 45-1 and woke up resident in 45 -2 [R47] in the process. I told [R47] the time and said she should lay back down and try and get some sleep until coffee time. [R47] said "No, I want to sit up I'm waiting." NA-C said "No lets lay down" and NA-C went to pick up [R47's] feet to bring them in bed and [R47] swung and hit me in the head, fairly hard. I [NA-C] yelled out "ow" and NA-C said "why did you hit me, R47 said "I didn't, you hit me you liar" then [NA-C] walked out and walkie the nurse...." This nurse [LPN-D] asked the res. why she hit the aide. Res. [R47] stated that the aide hit her."

An Incident Report submitted to the state agency on 1/28/15, indicated that R47 had a conflict with a nursing assistant on 1/24/15. Following a review of the related progress notes, and supervisory staff, it was originally determined R47's incident was due to her dementia. Further study revealed that R47 allegedly struck a nursing assistant, but resident [R47] also alleged the nursing assistant struck her. The report indicated

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a further investigation needed to be completed.

A follow-up Investigative Report was submitted to the state agency on 2/2/15. The report indicated the SW met with the resident R47 on the a.m. of 1/28/15 and 1/30/15 and resident was unable to recall any incidents of concerns. The SW was unable to speak with NA-C until 2/2/15 (7 days after the SW learned of the situation) in part due to her work schedule not coinciding with the SW. SW spoke with NA-C by phone on 2/2/15, at 10:45 p.m. NA-C acknowledged the incident happened as described by LPN-D's note. NA-C stated she had not struck R47 in any way, but had tried to lift R47's legs to help her lay down. The investigative report indicated the AP was NA-C. This report also included that NA-C had been implicated in a previous submitted report.

During interview 7/23/15, at 5:10 p.m., the SW stated the resident was unable to recall if the incident had happened, and said R47 had dementia. The SW said NA-C was not suspended during her investigation because it could "not be proved" that NA-C abused R47, and R47 continued to be on the work schedule. The SW said NA-C was counseled on how to provide cares for R47, and was asked for ideas from NA-C on how to keep R47 safe.

Review of the facility's MLHS-LTC NA/R Schedule indicated NA-C was not suspended pending the investigation of the incident dated 1/28/15 and NA-C was scheduled to work 1/28/15 and 1/29/15, while the investigation was in progress.

The investigation of this incident lacked timely interviewing of the NA-C. This incident occurred

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on 1/24/15 but was not reported to the SA until 1/27/15. The investigation did not determine if the R47 was actually abused. The facility did not suspend NA-C or take action to protect residents, during the investigation. There was no indication that a thorough investigation was completed for R47.

R47 had another facility Social Service Incident Referral Form (SSIRF), signed by RN-C indicated R47 was involved in an incident on "3/2/15 early a.m., of possible abuse or resident aggression." The SSIRF indicated: RN-C noted PCC notes (electronic progress notes) by LPN-B questioning verbal statements and other behaviors by resident [R47]; possible indication of maltreatment but just a likely symptoms of resident's dementia." The SSIRF further indicated the incident was discussed with Investigative Team on 3/3/15 at 8:30 a.m., and reported submitted to the state agency on 3/3/2015 at 12:30 p.m. The report also indicated NA-C was a person with credible knowledge of the situation.

An initial Incident Report was submitted to the state agency on 3/3/15 regarding possible abuse of R47 on 3/2/15. The report referenced "two progress notes from NOC (night) shift early that a.m. of 3/2 that suggests either some behavioral concerns/dementia symptoms by resident [R47] at work or possible maltreatment of resident by staff." The report indicated uncertainty by staff on whether this was maltreatment, and "SW decided to go ahead and submit the allegation to [state agency]...."

A nursing progress note, dated 3/2/215 at 4:03

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a.m., written by LPN-B, indicated [R47] was "kicking at staff" and [R47] told staff "she was going to report 'her' to the nurse.." The note also indicated R47 told staff "you go around hitting everyone I heard.." On 3/2/15 at 6:03 a.m., a second progress noted indicated staff went to wipe dry blood off [R47's] lip, and [R47] hit staff. The note continued, that after R47 hit staff, R47 stated "I am going to report you for hitting me."

Facility documentation did not indicate any action was taken to protect R47 and other residents during this investigation of potential abuse. Documentation of the investigation of this incident did not include determination the cause of R47's bloody lip, and there was no evidence of interview with the nursing assistant who provided cares for R47. The SSRIF also indicated there was no immediate reporting of this incident to the state agency or administrator.

A final, Investigative Report was submitted to the state agency on 3/06/15 regarding the incident. The report indicated on 3/2/15 the "resident was interviewed by RN Care Coordinator (RN- A) and this SW. Resident denied remembering anything happening this past weekend during the daytime or the nighttime that upset her in any way.....She denied that anyone hits her or has been mean to her or that she has hit anyone else." The report also indicated "SW communicated with [LPN-B] about progress notes from 3/2/15 during night shift, "indicating the NAR was situating resident in the EZ lift (mechanical lift) to help her to the bathroom per resident's request and the NAR noticed resident's lip had been bleeding apparently cracked from being chapped with dry, winter air. [NA-C] told [R47] she was going wipe the dried blood off, but R47 struck out at NA,

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causing NA's glasses to dismount from her face." The report indicated NA-C re-approached later and assisted [R47] without incident. Later the same night, the NA was doing rounds and attempted to lift R47's feet back in bed, and resident kicked at NA-C. The report then referenced the allegations made by R47, that she was slapped. The report did not confirm a perpetrator in this incident. The report indicated R47's care plan was reviewed, and suggestions were made on how to approach R47 during cares. The report also indicated LPN-B was coached by the SW and DON on more thorough progress note charting, and further, that staff have been reminded to submit timely incident reports. The report included: "Something is just not resting well with this, and although there is no maltreatment of residents 'substantiated' in this particular incident, SW will continue to keep eyes and ears open for patterns and/or trends in conduct, etc."

Review of the facility's MLHS-LTC NA/R Schedule from February 23, 2015 to March 8, 2015, indicated NA-C was assigned to work 3/2/15 (the night of the alleged incident) and also worked on 3/3/15.

During interview 7/23/15, at 5:30 p.m. the SW stated, in review of this incident, she had "concerns with NA-C" but again could not prove she had really done anything wrong. The facility felt they could not substantiate the allegations against NA-C, and therefore did not warrant a "suspension or discipline" during the investigation. There was no indication that a thorough investigation was completed for R47.

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R12's quarterly MDS dated 4/27/15 indicated she was moderately cognitively intact and needed extensive assist with dressing, bathing and grooming. R12's care plan dated 1/31/15, indicated she had potential for abuse from others related to cognitive impairment and limited mobility.

An initial Incident Report submitted to the state agency on 2/18/15, indicated that on 2/18/15, R12 was allegedly slapped, on her cheek, by a staff person who was attempting to administer medicine. The AP on the Incident Report was listed as unknown.

A final Investigative Report was submitted to the state agency on 2/23/15, regarding the incident. The report indicated R12 had made numerous allegations, but the only allegation that could be "tracked," was the one about someone slapping [R12] during the administration of Milk of Magnesia (MOM) that morning. Firstly, the report indicated the SW and DON proceeded to seek more information about who would have administered the MOM that morning. Per schedule, LPN-B and NA-C were the persons on duty. At 10:45 p.m. on 2/19/15, the DON and SW met with NA-C, who freely admitted having given MOM to R12 under direction of LPN-B. NA-C said "[R12] didn't want the MOM, and [R12] took the cup and threw the MOM all over." [NA-C] tried to clean it up off the bedding, resident's clothing and her face, using wet wipes." The report indicated NA-C denied slapping R12 in any way, but acknowledged wiping R12's face off with the wet ones. The report indicated, "It is possible this was perceived by [R12] as a slap." The SW asked NA-C to go to resident's room to see if resident could/would or would not identify

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her as the lady who slapped her, and NA-C agreed to do so. [R12] was sleeping soundly, however, so decided not awaken her. The report indicated "[NA-C's] willingness to go, however, leads SW to believe she [NA-C] is being truthful about not slapping resident." The report then indicated the DON spoke to LPN-B by phone on 2/23/15 at 3:20 p.m. LPN-C admitted asking NA-C to give MOM to R12 due to LPN being occupied elsewhere LPN-C also acknowledged that NA-C did report [R12's] claim of being slapped by a "blonde lady." The report then indicated staff have been alerted to have two persons present during cares with this resident and NA-C was instructed not to enter room without a colleague present.

During interview on 7/23/15, at 5:20 p.m. the SW stated she did not suspend NA-C since they could not prove NA-C slapped R12. The SW acknowledged NA-C had been involved in multiple incidents, and had "suspicions" with [NA-C], but did not feel "there was a reason to suspend" or provide disciplinary action to her during this investigation.

The investigation of this incident by the facility did not determine if R12 was slapped, nor was there follow up to have R12 positively identify the nursing assistant who provided cares. Although NA-C was instructed not to enter R12's room without a colleague present, the documentation offered no indication protections were put in place for other residents who were assisted by NA-C during this investigation of this incident, regardless of its outcome.

R22's admission MDS dated 4/24/15, indicated

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she had depression and a cerebral vascular accident (CVA), was moderately cognitively impaired and needed limited assist with transfers and extensive assist with toileting. R22's care plan dated 5/3/15, indicated she needed assist with toileting and transfers, had history of depression and sadness/isolating self. R22's care plan further indicated she had potential for abuse from others related to her general weakness, aches and pains. The care plan goal indicated "resident will remain safe and have needs met in a safe environment."

During observation on 7/20/15, at 5:54 p.m. R22 lifted her pant leg and displayed a bruise on her right shin measuring approximately 8 cm (centimeters) x 2 cm.. R22's bruise was black, fading to dark purple in color, with no apparent swelling

In an interview 7/20/15, at 5:54 p.m. R22 stated that she had been treated "roughly by the staff" and there is a staff member who works the night shift that is rough with her. R22 went on to state this staff member had "grabbed her arm when transferring" which caused a large bruise and also stated she had also hit her leg into the metal bar along the bottom of her bed.

The facility submitted an Incident Report to the state agency on 6/27/15, regarding an incident of alleged mistreatment and physical abuse of R22. The report also identified a bruise on R22's top right hand, measuring 5.5 cm x 5 cm, circular in shape; and a second bruise on R22's lower right shin 2.5 cm x 2.5 cm, circular in shape. The report was submitted by RN-D, and indicated that the initial reporter, NA-A, was also the alleged perpetrator in this incident. The report indicated,

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nursing assistant (NA)-C reported at 5:15 a.m., she had toileted R22, After being toileted, R22 told [NA-C] she was not coming back tonight,and that "some girl hurt her." NA-C asked who, and she [R22] stated she doesn't know who. The report then indicated that registered nurse (RN)-A, followed up with R22 in the morning and asked her to tell her what happened: "Resident reported she is not staying here again tonight and is not going to be treated like this anymore." R22 explained that staff was mad at her during the night for getting up to use the bathroom so many times, and that a "girl grabbed me and threw me into bed." R22 pointed out her hand hurt, and said "this is where she grabbed me," noted a bruise on top of right hand measures 5.5 cm (centimeters) x 5 cm circular is shape. R22 also reported when she threw me into bed, "I hit my leg on something metal;" a bruise noted on right outer lower shin measures 2.5 cm x 2.5 cm circular in shape. R22 could not recall who the girl was, nor her name. R22 thought it was around 0400. The report further indicated NA-C was the nursing assistant working on that wing during the night, and LPN-A was the nurse in charge. No other injuries noted, resident was reassured she will remain safe here, NA-C will be removed from working with resident at this time.

An additional Incident Report was submitted to the state agency on 7/1/15, which identified an injury of unknown source on R22's right forearm 8 x 5 cm, reddish purple in color, and oval in shape. The date of incident occurrence was unknown. The report indicated R22 said, "It happened a few days ago."

An Investigative Report was submitted to the state agency on 07/02/15, which combined the

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two submitted incident reports. The report indicated the DON and social worker SW "have tried to investigate this issue thoroughly and have been unable to substantiate who the alleged perpetrator [AP] is for certain, but have reached a conclusion there is reasonable suspicion a crime may have occurred in the form of assault, and are hence submitting a report also to law enforcement, in accordance with Elder Justice Act." Further, "The details of our internal investigation to the limits of our ability are being submitted to OHFC [Office of Health Facility Complaints] the state agency." The Investigative Report further indicated on 7/1/15, the DON and SW met with the AP, (NA-C) who stated R22 had requested to use the toilet 6-8 times that night (6/27/15). The report then indicated [SW and DON] "discussed with the AP the number of previous incidences involving this NAR, which can raise red flags re [regarding] her credibility, and she became somewhat defensive, face reddening and voice tightening, saying 'it's because I report things and others don't, so I end up getting in trouble.'" The report further listed, that during an interview 7/2/15 the DON and SW meet with NA-D, who stated she "reported having heard from resident (R22) on 6/30, that [R22] is afraid of the girl with the blonde hair and bangs, that she is not very nice, etc. The blond hair with the bangs fits description of NA-C. The report further included that NA-C had been "implicated in previous reports 75814, 78740, and 79433 with possible "power struggles" with residents, as she tries to perform cares; received coaching in these incidents. NA-C was also involved in report 79866 but was not specifically named as AP."

Although R22 had described NA-C as the staff member who had hurt her and NA-C was caring

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for her and received multiple large bruises, no disciplinary action was taken, NA-C was not suspended pending the investigation. Also, there was no indication that a thorough investigation was completed by the facility to include other interviews with staff and residents.

During interview on 7/23/15, at 4:50 p.m. the DON stated she has concerns that NA-C might be doing the accusations, but stated she was not certain. The DON said, "Staff monitor [NA-C] during the night shift," and "we have nurses on that do that." The DON stated the nurses were to report if they notice anything and have concerns.

In an interview on 7/23/15, at 5:03 p.m. the SW stated she did not talk with other residents or staff regarding abuse allegations by R22. The DON stated, "I don't generally do that, it's not a witch hunt." The DON said, "Just because their name keeps coming up does not make them guilty." The DON also said there were issues around "data privacy and confidentiality." SW further stated when something regarding abuse allegations come up over the weekend, the nurse on duty initiates the OHFC reporting. The SW said the nurse would talk to the resident, and address any immediate concerns. Regarding NA-C, the SW stated, "At times there have been several residents she is not allowed to care for, but that does change if, during the investigation the allegation is not substantiated." The SW further stated, in regard to NA-C, after the first allegation of abuse, "a lot of coaching was done." The SW also said the coaching for NA-C was "not intensive, and there was no improvement plan initiated and no documentation of education or mentoring done."

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During an interview on 7/23/15 at 5:10 p.m., the administrator said, "We have three young people working on nights, we can't suspend; there is not enough staff." The administrator further stated, " I feel the DON and SW did the right thing."

During an interview on 07/23/15, at 5:14 p.m. the DON stated NA-C was not suspended per the facility policy following the allegation made by R22 . She stated, "If I had suspended one, I would have had to suspend all three staff, then who would take care of the residents?"

During an interview on 07/24/15, 5:14 a.m., NA-E stated, " I don't work a lot of overnights unless I am mandated, but I do hear a few things." NA-E stated, "I have heard about people being super wet and I have heard that some of the girls are a little rough, but I can't tell you who." She further stated one of the residents mentioned about a girl being rough and leaving bruises. NA-E described the staff member as they were described by the resident and stated the resident said " the girl threw me into the chair because I had to go to the bathroom again." NA-E stated she does not see the nurse a lot on nights.

During interview on 7/24/15, at 5:25 a.m. LPN-H stated she works part time on the night shift. LPN-H stated she has heard from other NAs that NA-C is rough with the residents but had not witnessed it directly. LPN-H stated she was not aware that she was to monitor any staff during the night shift when she works. She further indicated she had heard R12 had reported that NA-C had slapped her and that NA-C no longer works on the North wing and thought the reason was because of the cat; not because she can not take care of any certain residents. She then

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stated the aides on the night shift don't work together they prefer to work on each unit alone.

INJURIES OF UNKNOWN ORIGIN

R39's annual MDS, dated 3/9/15, indicated she was moderately cognitively impaired. Her care plan, dated 3/30/15, indicated she required extensive assist with all activities of daily living, used a mechanical stand for transfers, and was at risk for abuse related to dementia.

Review of Social Service Incident Report Form, dated 10/7/14, indicated R39 had a large, dark purple bruise on the right upper portion of her buttock and that R39 was unaware of how the bruising occurred. The report indicated R39 had been lowered to floor by staff a few days prior to the bruise and indicated that may have caused the injury. The incident further indicated use of anticoagulant medication (used to prevent clotting) , other injuries/incidents over an unspecified times frame, and listed the injury as "minor." The injury was not reported to OHFC.

During an interview on 7/24/15, at 12:54 p.m., the DON)stated, when R39 had been lowered to the floor it would be hard to know if injury occurred during that event but stated, R39 bruised easily due to use of anticoagulant medication so therefore the injury was not considered reportable.

Although R39 was moderately impaired and unable to recall how the bruise occurred, there was no evidence that a more in-depth investigation was completed to determine the

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actual cause, nor was R39's injury of unknown origin reported to the state agency.

R11's quarterly MDS, dated 4/15/15, indicated she was moderately cognitively impaired. Care plan, dated 6/3/15, indicated R11 required extensive to total assist for all activities of daily living, was cognitively impaired, and at risk for abuse related to depression.

Review of three separate Social Services Incident Report Forms indicated R11 had injuries of unknown origin. An incident form dated 10/21/15, indicated R39 had a bruise to the top of her right hand that was dark purple in color and measured 8 cm x 8 cm. The report further indicated R11 was unable to state how the injury occurred, used blood thinners and described the injury as "minor." Another Social Services Report Form, dated 11/4/14, indicated R11 had bruising noted to her left temple and above her left eyebrow, and was unable to state the cause of the injury. A third incident report dated 12/18/14, indicated R11 had a bruise of unknown origin to her left inner knee, dark purple in color, measuring 1 x 1 3/4. (unit of measurement was not indicated). The report further indicated R11 was unable to report the cause of the injury, use of anticoagulant medications, and the injury was considered to be " minor." None of the three bruises were reported to OHFC.

During an interview on 7/24/15, at 12:54 p.m., SW stated, R11 "had more bruising than anyone I have ever known." She stated the bruise on R11's hand may have been caused by "recent trimming of [R11's] nails." Regarding the bruise noted to

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R11's temple and forehead, SW stated that nursing felt the bruising was due to placement of R11's nebulizer mask, however, SW interviewed R11 who reported that she slipped and fell on her way back from supper. SW further stated R11 did not ambulate, used a Hoyer lift for transfer and there were no records of any falls and indicated the bruising was likely due to placement of R11's nebulizer mask.

During an interview on 7/24/15, at 12:54 p.m., the DON stated R11 could reliably answer when asked if bruising was related to abuse, therefore, she felt the injury was not reportable.

Although R11 was identified to be moderately cognitively impaired, and had multiple bruises at different locations, and were unable to determine what happened, there was no indepth investigation completed to determine the actual causes of R11's bruises. The facility administrator was notified but none of these incidents were submitted to the state agency.

R66's quarterly MDS, dated 1/7/15, indicated she was moderately cognitively impaired. Care plan, dated 2/9/15, indicated R66 required extensive assist of two staff with use of mechanical lift for transfers, at risk for delirium, and at risk for abuse related to depression.

During review of a Social Service Incident Referral Form, dated 2/3/15, a facility progress noted indicated R66 had bruising along both arms from her hands to her shoulders. The form further indicated R66 was unable to state the cause of the injury and that the injury was assessed to be "minor." The injury was not reported to OHFC.

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During an interview on 7/24/15, at 12:54 p.m., SW stated, the bruises were noted while the DON was reviewing a progress note and she spoke with nursing and determined the bruising was assessed to be a minor injury and therefore not reportable to to OHFC.

During an interview on 7/24/15, at 12:54 p.m., the DON stated, R66 used a Hoyer lift (mechanical lift) and did not always cooperate in lift, occasionally "flailing her arms." She further stated, R66 was confused and that it would be "hard to say if R66 would have been able to to talk about how the bruising occurred after any time had passed."

Although R66 had bilateral bruising from her hands to her shoulders, the injury was unwitnessed and the resident was unable to identify what happened. The facility had not immediately reported the incident to the state agency nor was a thorough investigation completed to determine if R66 was "flailing her arms" while using the mechanical lift.

R44's annual MDS, dated 6/9/15, indicated she was severely cognitively impaired. Care plan, dated 7/10/15, indicated R44 required extensive assist with activities of daily living, and was at risk for abuse related to short term memory loss and impaired decision making skills.

Review of Social Service Incident Referral Form, dated 6/15/15, indicated R44 had a purple bruise on her posterior forearm measuring 6.3 cm x 7 cm that was found during her bath. The incident

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form indicated R66 did not state the cause of injury and that the injury was determined to be "minor."The bruise was not reported to OHFC.

During an interview on 7/24/15, at 12:54 p.m., SW stated, on 8/18/14, staff reported R8 had a bruise measuring 8.5 cm in length between her thumb and forefinger from the base of the thumb to her wrist. She stated the reporting nurse did the initial evaluation and determined the bruising resulted from R8 wringing her hands, and the wringing of her hands was witnessed by staff. She further stated the injury was not reportable due to staff witness of the potential cause. A Social Services Incident Referral form was requested for this injury but was not received.

During an interview on 7/24/15, at 12:54 p.m., SW stated when making a determination of whether or not to report an injury to OHFC, she refers to statutes, and uses a decision tree. SW also stated that she looks at whether a resident is able to explain the injury or if someone else saw it, and if there is a history of other recent falls and/or injuries. She further stated, if the nurses indicated minor injury or injury not suspicious in nature or location, it does not need to be reported.

During an interview on 7/24/15, at 12:54 p.m., the DON stated, there was no criteria for determining whether an injury was minor vs major. She further stated, the nurse finding the injuries did initial evaluation to determine the above injuries to be minor. The DON stated she would use the nurses judgement when determining if an injury was minor or major and that the RN in charge

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followed up on the injuries. However, she stated there was no charting in the clinical record that would show evidence that follow up had been completed.

Even though R44 was assessed to be severely cognitively impaired, had an injury of "unknown" origin, on the posterior of her arm. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency.

R8's quarterly minimum data set (MDS) identified her to be severely cognitively impaired and requiring assist of two staff for activities of daily living. CP dated 5/15/15 indicated R8 required extensive assist for activities of daily living and was at risk for abuse related to diagnosis of dementia.

A review of SSIRF dated 8/18/14, indicated R8 had a bruise measuring 8.5 cm in length between her thumb and forefinger from the base of her thumb to her wrist. The reporting nurse did the initial evaluation and determined the bruising resulted from R8 wringing her hands, and the wringing of her hands was witnessed by staff.

During an interview on 7/24/15, at 12:54 p.m., SW stated, the injury was not reportable due to staff witness of the potential cause. No further investigation of the injury was completed. The facility administrator was notified of the injury but a report was not made to the state agency. A Social Services Incident Referral form was requested for this injury but was not received.

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Although R8 had severe cognitive impairment, and had a bruise 8.5 cm between her thumb and forefinger from the base of her thumb to her wrist. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency.

Review of the facility Vulnerable Adult Policy, revised 7/15, indicated: "It is the policy of MLHS (Mille Lacs Health System) to protect adults who are vulnerable to abuse (including verbal, physical, mental psychosocial/emotional, and sexual abuse)..." The policy further indicated: "protection will include abuse prevention plans, individual abuse prevention plans, internal reporting of all cases of suspected abuse, neglect, or financial exploitation, and external reporting to the Common Entry Point (CEP) of substantiated incidents of maltreatment." In regard to investigation of a reportable incident, the policy stated: "All alleged violations are thoroughly investigated. The facility must prevent further potential abuse while the investigation is in progress." Under the "Protection for Resident or Patient" section, the policy directed that "The alleged perpetrator (AP) will be removed from the situation. If the AP is an employee, they will be suspended until the investigation is completed," and further, "Disciplinary action will be carried out up to and including dismissal of employee/employees as appropriate." The Policy defined Injury of Unknown Origin as "...source of the injury was not observed and injury as suspicious." The policy did not expound on this definition top include CMS definitions. In regard to screening of potential employees, the policy directed "MLHS will attempt to obtain information from previous employers and/or current

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F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement their Vulnerable Adult Policy to ensure all allegations of abuse, neglect, mistreatment and injuries of unknown origin were immediately reported to the administrator and state agency, were thoroughly investigated, and residents were protected during the investigations for 8 of 15 residents' (R47, R12, R22, R39, R11, R66, R44 and R8) allegations reviewed. In addition, the facility failed to conduct reference checks according to their policy for 4 of 5 newly hired employees (NA-A, NA-B, DA-A and RN-B). This had the potential to effect all 50 residents who resided in the facility, and resulted in substandard quality of care under resident behavior and facility practices. Findings include: The facility Vulnerable Adult Policy, revised 7/15, indicated: "It is the policy of MLHS (Mille Lacs Health System) to protect adults who are vulnerable to abuse (including verbal, physical, mental psychosocial/emotional, and sexual	F 226		

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abuse)..." The policy further indicated: "protection will include abuse prevention plans, individual abuse prevention plans, internal reporting of all cases of suspected abuse, neglect, or financial exploitation, and external reporting to the Common Entry Point (CEP) of substantiated incidents of maltreatment." In regard to investigation of a reportable incident, the policy stated: "All alleged violations are thoroughly investigated. The facility must prevent further potential abuse while the investigation is in progress." Under the "Protection for Resident or Patient" section, the policy directed: "The alleged perpetrator (AP) will be removed from the situation. If the AP is an employee, they will be suspended until the investigation is completed," and further, "Disciplinary action will be carried out up to and including dismissal of employee/employees as appropriate."

INVESTIGATION AND PROTECTION

During interview 7/23/15, at 5:09 p.m. with social worker (SW) stated that nursing assistant (NA)-C has been implicated in at least four incident reports from February 2015 to July 2015 of alleged abuse, and neglect.

Review of facility Incident and Investigation reports from 2/1/2015 to 7/20/2015 for NA-C identified the following:

R47's quarterly minimum data set (MDS) dated 2/17/15, indicated she was moderately cognitively intact and needed extensive assistance in ADLs. R47's care plan dated 2/26/15, indicated she had dementia and needs assist with dressing, grooming and bathing. The care plan further indicated she had slight alteration in cognition

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related to dementia and that resident will continue to be oriented to person, place and time.

A facility Social Service Incident Referral Form (SSIRF) indicated licensed practical nurse (LPN)-D verbally reported to the social worker (SW) on 1/27/2014, at 4 p.m., an incident that occurred during the night shift on 1/24/2015. The SSIRF, dated 1/27/15, indicated: "Alleged altercation/conflict between res [resident] & aides resulting in resident slapping aide and stating 'I didn't hit you, you hit me you liar.'" The SSIRF also indicated, "LPN separated aide & resident, assisted res to bed, escorted aide to hallway to inquire what happened." The SSIRF also indicated the incident required "further investigation and/or reporting" to the state agency, and this was signed by the SW on 1/28/15.

A review of Mille Lacs Nursing Home Progress Notes, dated 1/28/15, written by LPN-D indicated: "This nurse was in a res. room, 5 rooms away from where the incident happened, but heard a distinct smack. Followed by a woman's out cry. This nurse then got a call on the walkie [walkie-talkie] from the aide (nursing assistant, NA)." The [NA] stated (in her words) "On 2 a.m. rounds, I went to check resident in room 45-1 (room 45, bed 1) and woke up resident in 45-2 [R47] in the process. I told [R47] the time and said she should lay back down and try and get some sleep until coffee time." [R47] said "No, I want to sit up I'm waiting." NA said "No lets lay down" and NA went to pick up [R47's] feet to bring them in bed and [R47] swung and hit me in the head, fairly hard. I [NA] yelled out "ow" and NA said "why did you hit me, [R47] said, 'I didn't, you hit me you liar' then [NA] walked out and

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walkie the nurse...." This nurse [LPN-D] asked the res. why she hit the aide. Res. [R47] stated that the aide hit her." The nursing note did not identify the nursing assistant by name.

A facility email, written by the SW, dated 1/28/2015, indicated the SW had been verbally informed by LPN-D of R47 being in a conflict with a nursing assistant. The email indicated there was a progress note of the incident, but no further "incident report form." The email indicated the SW further reviewed the progress notes, and because the notes indicated "the resident allegedly struck a NAR [nursing assistant] and also that the resident claimed at the time that the NAR struck her, the incident DOES need to be reported" to the state agency.

An Incident Report submitted to the state agency on 1/28/15, indicated: "An incident was verbally reported to this SW in the late afternoon 1/27/15..." and further that R47 had a conflict "this past weekend" with a nursing assistant. Following a review of the related progress notes by the "Stand Up Team" and "Behavior Management Team", it was originally determined incident was due to [R47's] "dementia symptoms..." The report referred to a nursing progress note which indicated that [R47] "claimed at the time that the NAR struck her," thus requiring a report to the state agency, and "an internal investigation done accordingly as per policy." The alleged perpetrator (AP) was unidentified.

A review of the SSIRF, the internal email, and the initial report submitted to the state agency indicated an incident occurred sometime during the night shift/early morning hours of 1/25/14.

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The report also indicated the incident was first reported, and made known to the SW on late afternoon of 1/27/2014, (two days after the incident) and reported to the state agency on 1/28/2015 (three days after the incident allegedly occurred). There was no indication this incident was reported immediately to the administrator and state agency. Additionally, the investigation of this incident: lacked timely interviewing of NA-C, and other involved staff, and potentially affected residents; did not provide evidence R47 was thoroughly investigated for injuries; and lacked evidence of action to protect residents during the investigation.

A final Investigative Report was submitted to the state agency on 2/2/15. The report indicated the SW met with R47 "on the a.m. of 1/28/15 and 1/30/15," and "Resident unable to recall any incidents of concern with any aides the previous weekend." The SW was unable to speak with NA-C, (identified as the nursing assistant involved) until 2/2/15 (7 days after the SW learned of the incident) "in part due to her work schedule not coinciding with the SW." SW spoke with NA-C by phone on 2/2/15, at 10:45 p.m. NA-C "acknowledged the incident happened as described" by LPN-D's note, and further, "[NA-C] saying she had not struck resident in any way, but had merely tried to lift [R47's] legs to help her lay back down..." The report indicated "There is no apparent evidence of NAR striking resident." The investigative report indicated the alleged perpetrator was NA-C. This report also included that NA-C had been implicated in a previous submitted report.

During an interview 7/23/15, at 5:10 p.m., the SW

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stated in the investigation, R47 was unable to recall if the incident had happened, and that R47 had dementia. The SW said NA-C was not suspended during her investigation because it could not be proven that NA-C abused R47, and NA-C continued to be on the work schedule. The SW said NA-C was counseled on how to provide cares for R47, and was asked for ideas from NA-C on how to keep R47 safe.

Review of the facility's MLHS-LTC NA/R Schedule from January 26, 2014 to February 8, 2015, indicated NA-C worked on the night shift on 1/28/15 and 1/29/15, while the investigation of this incident was in progress.

R47 had another facility Social Service Incident Referral Form (SSIRF), signed by RN-C indicated R47 was involved in an incident on "3/2/15 early a.m., of possible abuse or resident aggression." The SSIRF indicated: RN-C noted PCC notes (electronic progress notes) by LPN-B questioning verbal statements and other behaviors by resident [R47]; possible indication of maltreatment but just a likely symptoms of resident's dementia." The SSIRF further indicated the incident was discussed with Investigative Team on 3/3/15 at 8:30 a.m., and reported submitted to the state agency on 3/3/2015 at 12:30 p.m. The report also indicated NA-C was a person with credible knowledge of the situation.

An initial Incident Report was submitted to the state agency on 3/3/15 regarding possible maltreatment of R47 on 3/2/15. The report referenced "two progress notes from NOC (night) shift early that a.m. of 3/2 that suggests either

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some behavioral concerns/dementia symptoms by resident [R47] at work or possible maltreatment of resident by staff." The report indicated uncertainty by staff on whether this was maltreatment, and "SW decided to go ahead and submit the allegation to [state agency]...."

A nursing progress note, dated 3/2/215 at 4:03 a.m., written by LPN-B, indicated [R47] was "kicking at staff" and [R47] told staff "she was going to report 'her' to the nurse.." The note also indicated R47 told staff "you go around hitting everyone I heard.." On 3/2/15 at 6:03 a.m., a second progress noted indicated staff went to wipe dry blood off [R47's] lip, and [R47] hit staff. The note continued, that after R47 hit staff, R47 stated "I am going to report you for hitting me."

Facility documentation did not indicate any action was taken to protect R47 and other residents during this investigation of potential abuse. Documentation of the investigation of this incident did not include determination the cause of R47's bloody lip, and there was no evidence of interview with the nursing assistant who provided cares for R47. The SSRIF also indicated there was no immediate reporting of this incident to the state agency or administrator.

A final, Investigative Report was submitted to the state agency on 3/06/15 regarding the incident. The report indicated on 3/2/15 the "resident was interviewed by RN Care Coordinator (RN- A) and this SW. Resident denied remembering anything happening this past weekend during the daytime or the nighttime that upset her in any way.....She denied that anyone hits her or has been mean to her or that she has hit anyone else." The report also indicated "SW communicated with [LPN-B]

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about progress notes from 3/2/15 during night shift, "indicating the NAR was situating resident in the EZ lift (mechanical lift) to help her to the bathroom per resident's request and the NAR noticed resident's lip had been bleeding apparently cracked from being chapped with dry, winter air. [NA-C] told [R47] she was going wipe the dried blood off, but R47 struck out at NA, causing NA's glasses to dismount from her face." The report indicated NA-C re-approached later and assisted [R47] without incident. Later the same night, the NA was doing rounds and attempted to lift R47's feet back in bed, and resident kicked at NA-C. The report then referenced the allegations made by R47, that she was slapped. The report did not confirm a perpetrator in this incident. The report indicated R47's care plan was reviewed, and suggestions were made on how to approach R47 during cares. The report also indicated LPN-B was coached by the SW and DON on more thorough progress note charting, and further, that staff have been reminded to submit timely incident reports. The report included: "Something is just not resting well with this, and although there is no maltreatment of residents 'substantiated' in this particular incident, SW will continue to keep eyes and ears open for patterns and/or trends in conduct, etc."

Review of the facility's MLHS-LTC NA/R Schedule from February 23, 2015 to March 8, 2015, indicated NA-C was assigned to work 3/2/15 (the night of the alleged incident) and also worked on 3/3/15.

During interview 7/23/15, at 5:30 p.m. the SW stated, in review of this incident, she had "concerns with NA-C" but again could not prove

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she had really done anything wrong. The facility felt they could not substantiate the allegations against NA-C, and therefore did not warrant a "suspension or discipline" during the investigation. There was no indication that a thorough investigation was completed for R47.

R12's quarterly MDS dated 4/27/15 indicated she was moderately, cognitively intact and needed extensive assist with dressing, bathing and grooming. R12's care plan dated 1/31/15, indicated she had potential for abuse from others related to cognitive impairment and limited mobility.

A facility Social Service Incident Referral Form (SSIRF), signed by the SW 2/18/15 at 4:15 p.m., indicated there was an incident on "2/18/2015 early A.M.", which alleged "Abuse." The incident was described as: "[NA)-I] asked SW to meet w/ Res re some issues. 9:30 a.m. Res told SW 'I want to go home, they're mean to me here.' 'The lady with the ponytail hurt me when she clean me up yesterday', and 'The other lady slapped me when she tried to make me drink white stuff.' At 4p.m. resident [R12] was still claiming similar concerns." The SSIRF also indicated the following: an internal email report was completed on 2/18/15; that the report of alleged abuse was received by the SW in person, no date or time listed; the incident was discussed with "Investigative Team" on 2/18/15 at 0833; and that the state agency initial report was submitted on 2/18/15 (no time indicated).

An initial Incident Report submitted to the state agency on 2/18/15, indicated on 2/18/15, R12

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was "slapped on her cheek by a staff person early this morning while staff person was trying to get her to take some medicine." The report indicated R12 had no apparent injuries, and "has been consistent with this claim throughout the day..." The report also indicated "a full internal investigation is warranted." The "alleged perpetrator" on the report form was listed as "unknown."

A review of the SSIRF, and the initial report to the State Agency indicated, that although this incident occurred in the early morning of 2/18/15, and possibly earlier, no action was taken by the facility or staff until it was discussed later that morning on 2/18/15. There was no indication the incident was immediately reported to state agency and administrator. Further, the investigation documentation of this incident did not indicate if R12 was slapped; and there was no follow up to have R12 positively identify the nursing assistant, (possibly NA-C) who provided her cares that day. Although NA-C was instructed not to enter R12's room without a colleague present, the documentation offered no indication protections were put in place for other residents who were assisted by NA-C during the investigation of this incident, regardless of its outcome.

A final Investigative Report was submitted to the state agency on 2/23/15. The final report indicated the "Initial Reports submitted to [state agency] ...at 4 p.m.," on 2/18/15, and also a call was made to local law enforcement. The report indicated R12 had made numerous allegations, but the only allegation that could be "tracked, was the one about someone slapping her during the administration of Milk of Magnesia (MOM) that

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morning (the white stuff)." The report indicated SW and DON proceeded to seek more information about who would have administered the MOM that morning. The report identified, according to the schedule, LPN-B and NA-C were the persons on duty. Further, the report indicated, "DON and SW met with [NA-C], who freely admitted having given MOM upon the direction of [LPN-B]." The report continued, "[NA-C] said resident didn't want the MOM, and resident took the cup and threw the MOM all over." and "[NA-C] tried to clean it up off the bedding, resident's clothing and her face, using wet wipes." The report indicated "[NA-C] denied slapping resident in any way, but acknowledged wiping R12's face off with the wet ones." The report indicated "It is possible this was perceived by [R12] as a slap." Next, the report indicated, the SW asked NA-C to go to resident's room to see if resident could or would identify her as the lady who slapped her, and NA-C agreed to do so. "[R12] was sleeping soundly, however, so decided not awaken her." The report indicated "NA-C's willingness to go, however, leads SW to believe she [NA-C] is being truthful about not slapping resident." The report indicated the DON spoke to LPN-B by phone on 2/23/15 at 3:20 p.m. LPN-C admitted asking NA-C to give MOM to R12 due to LPN-C being occupied elsewhere LPN-C also acknowledged that NA-C did report (R12's) claim of being slapped by a "blonde lady." The report then indicated staff have been alerted to having "two persons present" during cares with this resident and NA-C was instructed not to enter room without a colleague present.

During interview on 7/23/15, at 5:20 p.m. the SW stated she did not suspend NA-C since "they could not prove [NA-C] slapped [R12.]" The SW

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acknowledged NA-C had been involved in multiple incidents, and had "suspicions" with [NA-C], but did not feel "there was a reason to suspend" or provide disciplinary action to her during this investigation.

Review of the facility's MLHS-LTC NA/R Schedule from February 9, 2015 to February 22, 2015, indicated NA-C worked on 2/17/15 through 2/22/2015, that is on the date of the alleged incident, and during the subsequent investigation. There was no indication a thorough investigation was completed for R12.

R22's admission MDS dated 4/24/15, indicated she had depression and a cerebral vascular accident (CVA), and was moderately cognitively impaired and needed limited assist with transfers and extensive assist with toileting. R22's care plan dated 5/3/15, indicated she needed assist with toileting and transfers, had history of depression and sadness/isolating self. R22's care plan further indicated she had potential for abuse from others related to her general weakness, aches and pains. The care plan goal indicated "resident will remain safe and have needs met in a safe environment."

During observation on 7/20/15 at 5:54 p.m., R22 lifted her pant leg and displayed a bruise on her right shin measuring approximately 8 cm (centimeters) x 2 cm. R22's bruise was noted to be black, fading to dark purple in color, with no apparent swelling. In an interview 7/20/15, at 5:54 p.m. R22 stated that she had been treated "roughly by the staff" and there is "a staff member who works the night shift that is rough with her."

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R22 went on to state this staff member had "grabbed her arm when transferring" which caused a large bruise and also stated she had also hit her leg into the metal bar along the bottom of her bed.

The facility submitted an Incident Report to the state agency on 6/27/15 regarding an incident of alleged mistreatment and physical abuse of R22. The report also identified a bruise on R22 top right hand, measuring 5.5 cm x 5 cm, circular in shape; and a second bruise on R22's lower right shin 2.5 cm x 2.5 cm, circular in shape. The report was submitted by RN-D, and indicated that the initial reporter, NA-C, was also the alleged perpetrator in this incident. The report indicated, nursing assistant (NA)-C reported at 5:15 a.m., she had toileted R22, after being toileted, R22 told [NA-C] she was not coming back tonight,and that "some girl hurt her." NA-C asked who, and she [R22] stated she doesn't know who. The report then indicated that registered nurse (RN)-A, followed up with R22 in the morning and asked her to tell her what happened: "Resident reported she is not staying her again tonight and is not going to be treated like this anymore." R22 explained that staff was mad at her during the night for getting up to use the bathroom so many times, and that a "girl grabbed me and threw me into bed." R22 pointed out her hand hurt, and said "this is where she grabbed me," noted a bruise on top of right hand measures 5.5 cm (centimeters) x 5 cm circular is shape. R22 also reported when she threw me into bed, "I hit my leg on something metal" a bruise noted on right outer lower shin measures 2.5 cm x 2.5 cm circular in shape. R22 could not recall who the girl was, nor her name. R22 thought it was around 0400. The report further indicated NA-C

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was the nursing assistant working on that wing during the night, and LPN-A was the nurse in charge. No other injuries noted, resident was reassured she will remain safe here, NA-C will be removed from working with resident at this time.

An additional Incident Report was submitted to the state agency on 7/1/15, which identified an injury of unknown source on R22's right forearm "8 x 5 cm, reddish purple in color and oval in shape." The date of incident occurrence was unknown. The report indicated R22 said "It happened a few days ago."

An Investigative Report was submitted to the state agency on 07/02/15, which combined two submitted incident reports dated 6/27/15 and 7/1/15. The report indicated the director of nursing (DON) and social worker (SW) "have tried to investigate this issue thoroughly and have been unable to substantiate who the alleged perpetrator [AP] is for certain, but have reached a conclusion there is reasonable suspicion a crime may have occurred in the form of assault, and are hence submitting a report also to law enforcement, in accordance with Elder Justice Act." Further the report indicated, "The details of our internal investigation to the limits of our ability are being submitted to OHFC and the state agency." The Investigative Report further indicated on 7/1/15, the DON and SW met with the AP, (NA-C) who stated R22 had requested to use the toilet 6-8 times that night (6/27/15). The report then indicated [SW and DON] "discussed with the AP the number of previous incidences involving this NAR, which can raise red flags re her credibility, and she became somewhat defensive, face reddening and voice tightening, saying 'it's because I report things and others

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don't, so I end up getting in trouble.' " The report further listed, that during an interview 7/2/15 the DON and SW meet with NA-D, who stated she "reported having heard from resident (R22) on 6/30, that [R22] is afraid of the girl with the blonde hair and bangs, that she is not very nice, etc. The blond hair with the bangs fits description of NA-C. The report further included that NA-C had been "implicated in previous reports 75814, 78740, and 79433 with possible "power struggles" with residents, as she tries to perform cares; received coaching in these incidents. NA-C was also involved in report 79866 but was not specifically named as AP."

Although R22 had described NA-C as the staff member who had hurt her and NA-C was caring for her and received multiple large bruises, the incident documentation indicated no action taken to protect residents during investigation of these incidents. Also, there was no indication that a thorough investigation was completed that included other interviews with staff and residents.

During interview on 7/23/15, at 4:50 p.m. the DON stated she "has concerns that NA-C might be doing the accusations," but stated she "was not certain." The DON said, "staff monitor [NA-C] during the night shift," and also "we have nurses on that do that." The DON stated the nurses were to report to her if they notice anything and have concerns.

In an interview on 7/23/15, at 5:03 p.m., the SW stated she "did not talk with other residents or staff regarding abuse allegations by [R22]." The DON stated, "I don't generally do that, it's not a witch hunt." The DON said, "Just because their name keeps coming up does not make them

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guilty." The DON also said there were issues around "data privacy and confidentiality." SW further stated, when something regarding abuse allegations come up over the weekend, the nurse on duty initiates the OHFC reporting. The SW said the nurse would talk to the resident, and address any immediate concerns. Regarding NA-C, the SW stated, "At times there have been several residents she is not allowed to care for, but that does change if, during the investigation the allegation is not substantiated." The SW further stated, in regard to NA-C, after the first allegation of abuse, " a lot of coaching was done." The SW also said the coaching for NA-C was "not intensive, and there was no improvement plan initiated and no documentation of education or mentoring done."

During an interview on 7/23/15 at 5:10 p.m., the administrator said, "We have three young people working on nights, we can't suspend; there is not enough staff." The administrator further stated, " I feel the DON and SW did the right thing."

During an interview on 07/23/15, at 5:14 p.m., the DON stated NA-C was not suspended per the facility policy following the allegation made by R22 . She stated, "If I had suspended one, I would have had to suspend all three staff, then who would take care of the residents?"

During an interview on 07/24/15 5:14 a.m., NA-E stated, " I don't work a lot of overnights unless I am mandated, but I do hear a few things." NA-E stated, "I have heard about people being super wet and I have heard that some of the girls are a little rough, but I can't tell you who." She further stated, one of the resident mentioned about a girl being rough and leaving bruises. NA-E described

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the staff member as they were described by the resident and stated the resident said " the girl threw me into the chair because I had to go to the bathroom again." NA-E stated she does not see the nurse a lot on nights.

During interview on 7/24/15, at 5:25 a.m. LPN-H stated she works part time on the night shift. LPN-H stated she has heard from other NAs that NA-C is rough with the residents but had not witnessed it directly. LPN-H stated she is not aware that she is to monitor any staff during the night shift when she works. She further indicated she had heard R12 had reported that NA-C had slapped her and also that NA-C no longer works on the North wing and thought the reason was because of the cat not because she can not take care of any certain residents. She then stated the aides on the night shift don't work together they prefer to work on each unit alone.

INJURIES OF UNKNOWN ORIGIN

The facility Vulnerable Adult Policy, revised 7/15, defined Injury of Unknown Origin as "...source of the injury was not observed and injury as suspicious." The policy did not expound on this definition to include criteria from the CMS interpretive guidance.

R39's annual MDS, dated 3/9/15, indicated she was moderately, cognitively impaired. The CP, dated 3/30/15, indicated R39 required extensive assist with all activities of daily living (ADLs), used a mechanical stand for transfers, and was identified at risk for abuse, because of dementia.

A review of SSIRF dated 10/7/14, indicated R39

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had a large, dark purple bruise on the right upper portion of her buttock, and it was an "unknown" injury, and R39 was "unaware" of how the bruising occurred. The SSIRF also indicated R39 "a few days ago had been lowered to floor due to not standing when transferring & then lifted with Hoyer (a mechanical lift) Possible cause." The SSRIF further indicated R39 used a medication that could explain bruising, and also that R39's chart contained "falls or other recent incidents that could likely have produced the injury." The SSIRF indicated R39's injury was "minor" and not reported to the state agency. No further investigation was completed for this incident even though there was no indication R39 had struck any objects or the floor as she was lowered to the ground.

During an interview on 7/24/15, at 12:54 p.m., the DON stated, when R39 had been lowered to the floor "it would be hard to know if injury occurred during that event." The DON said R39 bruised easily due to use of anticoagulant medication, so therefore the injury was "not considered reportable."

Although R39 was moderately impaired and unable to recall how the bruise occurred, there was no evidence that a more in-depth investigation was completed to determine the actual cause, nor was R39's injury of unknown origin reported to the state agency.

R11's quarterly MDS, dated 4/15/15, indicated she was moderately, cognitively impaired. The CP, dated 6/3/15, indicated R11 required extensive to total assist for all ADLs, and was at

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risk for abuse related to depression.

A review of SSIRF dated 10/21/15, indicated R39 had a bruise to the top of her right hand, dark purple in color, and measured 8 cm x 8 cm. The SSIRF indicated R11 was unable to state how the injury occurred, but R11 used anticoagulant medication, and R11's bruise was described as "minor." The facility administrator was notified but no report was made to the state agency.

A second SSIRF, dated 11/4/14, indicated R11 had bruising noted to her left temple and above her left eyebrow. The SSIRF indicated R11 was unable to state the cause of the injury. The facility administrator was notified, but the injury was not reported to the state agency.

A third SSIRF dated 12/18/14, indicated R11 had a bruise of unknown origin to her left inner knee, dark purple in color, and measuring 1 x 1 3/4 inches. The SSIRF indicated the injury was "unknown", that R11 was unable to report the cause of the injury, used anticoagulants; and also indicated the injury was considered to be "minor." The facility administrator was notified, but the injury was not reported to the state agency.

During an interview about the three injuries of unknown origin on 7/24/15, at 12:54 p.m., the SW stated, R11 "had more bruising than anyone I have ever known." The SW said the bruise on R11's hand "may have been caused by recent trimming of [R11's] nails," indicating R11 caused the bruise herself. Regarding the bruise noted to R11's temple and forehead, the SW stated that nursing felt the bruising "was due to placement of [R11's] nebulizer mask," however, the SW stated, she interviewed R11 who reported that

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she slipped and fell on her way back from supper. SW further stated R11 did not ambulate, used a Hoyer lift [a mechanical lift] for transferring, and there were no records of any falls. SW added the bruising was "likely due to placement of [R11's] nebulizer mask." No further investigation was completed for this injury.

During an interview on 7/24/15, at 12:54 p.m., the DON stated R11 "could reliably answer" when the reporting nurse asked if bruising was related to abuse, therefore, the DON felt the injury was not reportable.

Although R11 was identified to be moderately cognitively impaired, and had multiple bruises at different locations, there was no indepth investigation completed to determine the actual causes of R11's bruises. The facility administrator was notified of the injuries but none of these incidents were submitted to the state agency.

R66's quarterly MDS, dated 1/7/15, indicated she was moderately, cognitively impaired. The CP, dated 2/9/15, indicated R66 required extensive assist of two staff, with use of a mechanical lift, for transfers. The CP also indicated R66 was at risk for delirium and potential abuse, related to depression.

A review of SSIRF dated 2/3/15, indicated during a review of R66's nursing progress note dated 1/26/2015, there was "presence of unknown bruises" on [R66] both arms, the size was identified as bruising "from hands to shoulder." The SSIRF also indicated R66 now wore sleeve/arm protectors. The SSIRF indicated this

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was an "unknown injury", that R66 was unable to state the cause, and that the injury was assessed to be "minor." The injury was reported to the facility administrator, but was not not reported to the state agency.

During an interview on 7/24/15, at 12:54 p.m., the SW stated, the bruises were noted while the DON was reviewing R66's progress notes. The SW said she "spoke with nursing" and determined the bruising was assessed "to be a minor injury, and therefore not reportable to the state agency."During an interview on 7/24/15, at 12:54 p.m., the DON said R66 used a Hoyer lift (mechanical lift), and R66 did not always cooperate in lift, occasionally "flailing her arms." The DON further stated R66 was confused, and that it would be "hard to say if R66 would have been able to to talk about how the bruising occurred after any time had passed."

Although R66 had bilateral bruising from her hands to her shoulders, the injury was unwitnessed and the resident was unable to identify what happened. The facility had not immediately reported the incident to the state agency nor was a thorough investigation completed to determine if R66 was "flailing her arms" while using the mechanical lift.

R44's annual MDS, dated 6/9/15, indicated she was severely cognitively impaired. The CP, dated 7/10/15, indicated R44 required extensive assist with ADLs, and was at risk for abuse, related to short term memory loss and impaired decision-making skills.

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A review of SSIRF dated 6/15/15, indicated R44 had a purple bruise on her posterior (back side) forearm, measuring 6.3 cm x 7 cm, that was found during her bath. The SSIRF indicated this was an "unknown" injury, and R66 could not state the cause of injury. The injury was determined to be "minor". The facility administrator was notified, but the injury was not reported to the state agency.

During an interview on 7/24/15, at 12:54 p.m., the SW stated, "The injury was determined by nursing staff to be 'minor' and did not meet any suspicious criteria. The SW said she "did not see a need to report" to the state agency.

In an interview on 7/24/15, at 12:54 p.m., the DON stated, "[R44] would have been able to tell you if something happened, she could make her needs known."

Even though R44 was assessed to be severely cognitively impaired, had an injury of "unknown" origin, on the posterior of her arm. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency.

R8's quarterly minimum data set (MDS) identified her to be severely cognitively impaired and requiring assist of two staff for activities of daily living. CP dated 5/15/15 indicated R8 required extensive assist for activities of daily living and was at risk for abuse related to diagnosis of dementia.

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F 226	Continued From page 45 A review of SSIRF dated 8/18/14, indicated R8 had a bruise measuring 8.5cm in length between her thumb and forefinger from the base of her thumb to her wrist. The reporting nurse did the initial evaluation and determined the bruising resulted from R8 wringing her hands, and the wringing of her hands was witnessed by staff. During an interview on 7/24/15, at 12:54 p.m., SW stated, the injury was not reportable due to staff witness of the potential cause. No further investigation of the injury was completed. The facility administrator was notified of the injury but a report was not made to the state agency. A Social Services Incident Referral form was requested for this injury but was not received. Although R8 had severe cognitive impairment, and had a bruise 8.5cm between her thumb and forefinger from the base of her thumb to her wrist. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency. During an interview on 7/24/15, at 12:54 p.m., SW stated, when making a determination of whether or not to report an injury to the state agency, she "refers to statutes, and uses a decision tree." The SW also stated that she looks at whether a resident is able to explain the injury, or if someone else saw it, and if there was a history of other recent falls and/or injuries. The SW further stated, "If the nurses indicated minor injury or injury not suspicious in nature or location, it does not need to be reported."	F 226		

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During an interview on 7/24/15, at 12:54 p.m., the DON said, minor injuries are not reportable to the state agency. She further stated, there was "no criteria or policy" the facility has to identify and determine whether an injury was "minor" versus "major." The DON also stated she "would use the nurses judgement" when determining if an injury was minor or major, and that the RN in charge "followed up on the injuries." However, she stated there was no charting on the clinical record that would show evidence that follow-up had been completed.

REFERENCE CHECKS

The facility's Abuse Prevention Policy, revised 7/15, indicated as its purpose "...to protect adults who are vulnerable to abuse..." Further, the policy included: "To assure the facility was doing everything within its control to prevent the occurrence of abuse or neglect...the facility would attempt to obtain information from previous employers and or/current employers."

NA-A's personnel record identified they were hired on 7/13/15. The personnel record lacked evidence reference checks were completed prior to employment at the facility.

NA-B's personnel record identified they were hired on 6/30/15. The personnel record lacked evidence reference checks were completed prior to employment at the facility.

Dietary Aide (DA)-A's personnel record identified they were hired on 6/23/15. The personnel record lacked evidence reference checks were

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F 226	Continued From page 47 completed prior to employment at the facility. Registered nurse (RN)-B's personnel record identified they were hired on 5/11/15. The personnel record lacked evidence reference checks were completed prior to employment at the facility. On 7/23/15, at 8:45 a.m. human resources (HR) staff stated four of the five newly hired employees did not have documentation of reference checks. HR stated there was "not a process" to document that reference checks had been completed. They facility used the application references "to inquire about the position held, date of hire, eligibility for rehire and any feedback."	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified rising and morning routines for 2 of 8 residents (R50 and R12),who required extensive staff assistance to complete activities of daily living (ADL's). R50's diagnoses, as identified on the care plan (CP), reviewed 6/6/2015, included hemiplegia, dementia, and aphasia. The quarterly Minimum Data Set (MDS), dated 5/27/2015, indicated R50	F 241		

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had severely impaired cognition, required extensive, physical assistance for ADL's, including two-person assist with bed mobility, transfers, toileting, dressing and personal hygiene.

During observation on 7/22/2015 at 7:11 a.m., R50 was lying on her back, in her bed, with her left hand positioned on top of her chest. R50's blanket was at the foot of the bed, pulled onto the resident, exposing R50's left leg, and one could see she already had pants on as she lied in bed. R50 remained in bed until 8:41, when NA-F and NA-G assisted her with morning cares. R50 was already dressed, with pants, socks and shirt, when NA-F removed R50's covers and checked for incontinence, NA-F and NA-G assisted R50 into her wheel chair with use of a mechanical lift. NA-F then brushed her hair, and NA-G assisted in placing R50's hand splint and arm into the wheel chair armrest and R50 was up for the day.

During an interview on 7/22/2015 at 8:38 a.m., NA-G said R50 was already dressed this morning, and we "just needed to get up, out of bed." NA-G said R50 needed "total assistance" dressing, and R50 was not able to verbalize her needs to staff.

In an interview on 7/22/2015 at 9:18 a.m., NA-F acknowledged R50 was dressed this morning when she assisted R50 to get up for the day. NA-F did not know who worked with R50, but said "someone on nights [the night shift] got her dressed," and that was typical for R50's routine. NA-F also said R50 would not be dressed early on Tuesdays, "because she gets a bath on that day."

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During an interview on 7/24/2015 at 6:00 a.m., NA-H stated she works on the overnight shift, and routinely got R50 "cleaned up and dressed," but not removed from bed, "the day shift would do that." NA-H stated she does not get R50 dressed on her scheduled bath days. She has a list of residents whom she helped get cleaned and dressed, prior to the end of the night shift. NA-H said "I just need to make sure they are dressed and ready to go. I get them dressed and then put them back to bed; it helps out the morning shift." NA-H said if there was a resident that did not want to get up, she was instructed "to get someone else up." NA-H did add that some of the residents she assisted "liked to get up early," and there were some who simply "were up all night anyway."

During an interview on 7/24/2015 at 1:06 p.m., family member (FM)-A said he was unaware staff were getting R50 dressed, then having her stay in bed. FM-A said that depending on the night, R50 was often awake late, or was "up at 3:00 a.m. and restless, and they [staff] will get her up." FM-A than stated, "I would think if [R50] got dressed, she'd be getting out, and up to breakfast for the day."

In an interview on 7/24/2015 at 1:17 p.m., the director of nursing (DON) stated the night shift try "to help the day shift staff." The DON said "If someone was trying to get up, then get them up, and keep [the resident] from getting out of bed and possibly fall." In the same interview, the social worker (SW) said getting a resident up during the night was "not just a decision for the aide. We should look into this some more."

R12's quarterly minimum data set (MDS), dated

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5/18/15, indicated she was severely, cognitively impaired and required extensive assist for transfers, dressing and grooming. The care plan (CP), dated 8/28/13, directed staff to give R12 opportunities to make daily preferences choices, including clothing, bed time and bathing. The CP also indicated R12 had an alteration in sleep, related to insomnia, with a goal of at least six hours of sleep at night. The CP did not address a morning routine preference of when R12 wanted to get up.

During observation on 7/22/15 at 7:00 a.m., R12 was noted fully dressed and seated in her wheel chair. R12 was positioned in front of the television in the common area on the east wing, asleep in her wheelchair. R12 repeatedly made jerking movements as she dozed. R12 remained in chair until 8:15 a.m., (75 minutes) when staff approached, and awakened her. The staff asked R12 if if she wanted to go back to bed, or eat breakfast. R12 replied "I don't care."

During an interview on 7/24/15, at 5:59 a.m., NA-E stated she was instructed to get four residents up, washed and dressed when working the over night shift. NA-E stated if a resident had shower, there was another one assigned to get up in their place. NA-E stated she will usually "get the residents up, washed, dressed and put them back to bed."

During an interview on 7/24/15 12:24 p.m., licensed practical nurse (LPN)-C stated, " usually the over night shift is getting up the early risers, she stated they are not getting up anyone that would normally sleep in. LPN-C further stated, "Some of the Hoyers [residents who require use

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of a mechanical lift to transfer] get washed, dressed and put back in bed, I don't have any idea why they would do that."

During an interview on 7/24/15, at 1:16 p.m., the director of nursing (DON) stated, there are many people getting up and dressed and put back to bed on the night shift. She stated, The nurses and care coordinators schedule them to help the day shift. The DON further stated, "the people on this list are usually up or crawling out of bed," we like the night shift to help day shift "get a jump on the day." She further stated, "I'm sure we are not the only nursing home in the world that does that." The intent is to help day shift out and prevent falls. The DON stated she was not sure if the rationale for waking a resident on night shift to get them washed and dressed is on the care plan or not.

During an interview on 7/24/15, at 2:07 p.m., registered nurse (RN)-C stated, We schedule residents for the night shift to get up, washed and dressed. She stated, We usually look at people who are trying to get up but if there aren't enough people who want to get up, we will pick people who are a "Hoyer lift." The aides will wash and dress them in bed. RN- C stated, "If someone prefers to get up early it is not care planned." She further stated, there is no one currently on the East unit that is care planned to get up early due to fall risk. RN-C stated, The rationale for night shift getting resident's washed and dressed is due to the workload in the morning.

Review of the facility's undated East night group sheet directed night shift to complete morning cares, oral cares, dressing, making bed and cleaning up room for five residents on the unit,

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F 241	Continued From page 52 including R12. A review of the facility policy, Rights and Responsibilities of Patients/Residents, dated 4/15, indicated the facility "must, with courtesy, promote care for [residents] in a manner that maintains and enhances dignity and respect in full recognition of [a resident's] individuality."	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care for timely repositioning and toileting assistance for 1 of 1 residents (R50) with urinary incontinence, and at risk for pressure ulcer development. Findings include: R50's diagnoses, as identified on the care plan (CP), reviewed 6/6/2015, included hemiplegia affecting dominant side, dementia, and aphasia due to cerebrovascular disease. The quarterly Minimum Data Set (MDS), dated 5/27/2015, indicated R50 had severely impaired cognition, and was unable to walk. The MDS also identified R50 required extensive, physical assistance for activities of daily living (ADLs), including two-person assist with bed mobility, transfers,	F 282		

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toileting, and personal hygiene.

R50's care plan (CP) identified the potential for alteration in skin integrity, and also R50's alteration in elimination/toileting. The CP directed staff to follow the mobility plan of care, and assist R50 "to turn and reposition every 2 hours and PRN" [as needed]. Additionally, the CP directed staff to assist R50 "to check and change every 2 hours and PRN" [as needed].

During continuous observation on 7/23/2015 from 7:55 a.m. to 11:12 a.m. (3 hours and 7 minutes) R50 was observed to be dressed and seated upright in her wheel chair. At 7:55 a.m., R50 was seated in her wheel chair in the living area across from the north unit nursing station and watching a news program on TV. At 8:33 a.m., R50 was wheeled into the dining room and assisted with breakfast, finishing at 9:36 a.m. Following the meal, and still seated in the wheel chair, R50 was moved from the table where food was served to the activity area in the same room. R50 participated in the morning activity, and stayed in the activity area until just after 10:00 a.m., when a staff member wheeled her into the main entryway of the facility. R50 remained there, still seated in her wheel chair, until 10:19 a.m., when a staff member pushed R50 outside of the building, joining other residents to get fresh air. At 10:37 a.m., R50 was returned into the building near the aviary, and was approached by nursing assistant (NA)-F, who after greeting R50, took her vital signs. More than 2 1/2 hours had elapsed since R50 was last toileted or repositioned. R50 remained seated in her wheel chair near the aviary until 11:12 a.m., when NA-F assisted her back to her room. In her room, NA-F and registered nurse (RN)-B, using the mechanical

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F 282	Continued From page 54 lift, assisted R50 into her bed. R50 was incontinent of urine, and NA-F provided perineal care. RN-B assessed R50's skin, which was pink in color, free of any unusual warmth or swelling, there were no reddened areas, and her skin was fully intact. RN-B also said R50 was incontinent of urine. R50 was not toileted or repositioned from 7:55 a.m. to 11:12 a.m., a total of 3 hours and 7 minutes. During an interview on 7/23/2015 at 11:16 a.m., nursing assistant (NA)-F stated R50 was last repositioned when she was put in her wheel chair "at about quarter to eight." NA-F then stated R50 was on an "every two hour repo [repositioning] schedule," and that R50 should also be checked for "urinary incontinence." NA-F said R50 "Was definitely ready to be repositioned." In an interview on 7/23/2015 at 4:00 p.m. registered nurse (RN)-A said she "trusted the work group on the floor to get toileting and repositioning completed," but what happened today, "I'll say was a fluke." RN-A also stated, "I'll be honest, [R50] should have been turned." During an interview on 7/27/2015 at 1:19 p.m., the director of nursing (DON) said resident interventions were care planned, and the facility takes "very seriously, residents' needs for timely assistance." A facility policy regarding the implementation of care plans was requested, but none provided.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314		

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resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide timely repositioning for 1 of 2 residents (R50) reviewed in the sample identified at risk for development of pressure ulcers.

Findings include:

R50's diagnoses, as identified on the care plan (CP), reviewed 6/6/2015, included hemiplegia affecting dominant side, dementia, and aphasia due to cerebrovascular disease. The quarterly Minimum Data Set (MDS), dated 5/27/2015, indicated R50 had severely impaired cognition, and was unable to walk. The MDS also identified R50 required extensive, physical assistance for activities of daily living (ADLs), including two-person assist with bed mobility, transfers, toileting, and personal hygiene. A Braden Pressure Sore Risk Assessment, dated 5/26/2015, indicated R50 was at moderate risk for development of pressure sores. A comprehensive skin assessment summary, dated 5/26/2015, identified R50 required extensive to total assist with ADLs, that she was unable to walk, and was on a turn-and-reposition schedule every 2 hours. The care area assessment (CAA)

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for pressure ulcers, dated 2/25/2015, identified additional pressure ulcer risk factors for R50 including immobility, incontinence, cognitive loss and functional limitation in range of motion.

R50's CP identified the potential for alteration in skin integrity. The CP directed staff to follow the mobility plan of care, and assist R50 "to turn and reposition every 2 hours and PRN" [as needed]. The nursing assistant care sheet "North" unit, undated, directed for R50: T & R q 2 hrs [turn and reposition every 2 hours].

During continuous observation on 7/23/2015 from 7:55 a.m. to 11:12 a.m. (3 hours and 7 minutes) R50 was observed to be dressed and seated upright in her wheel chair, with her right hand and wrist fitted with a splint device, and her right arm was supported and strapped into the arm rest. At 7:55 a.m., R50 was seated in her wheel chair in the living area across from the north unit nursing station and watching a news program on TV. At 8:33 a.m., R50 was wheeled into the dining room and assisted with breakfast, finishing at 9:36 a.m. Following the meal, and still seated in the wheel chair, R50 was moved from the table where food was served to the activity area in the same room. R50 participated in the morning activity, and stayed in the activity area until just after 10 a.m., when a staff member wheeled her into the main entryway of the facility. R50 remained there, still seated in her wheel chair, until 10:19 a.m., when a staff member pushed R50 outside of the building, joining other residents to get fresh air. At 10:37 a.m., R50 was returned into the building near the aviary, and approached by nursing assistant (NA)-F, who after greeting R50, took her vital signs. More than 2 1/2 hours had elapsed since the initial observation, and still R50

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was not off loaded, or repositioned out of her wheel chair. R50 remained seated in her wheel chair near the aviary until 11:12 a.m., when NA-F assisted her back to her room. In her room, NA-F and registered nurse (RN)-B, using the mechanical lift, assisted R50 into her bed. R50 was incontinent of urine, and NA-F provided cleansing cares for her. In the presence of the surveyor, RN-B inspected and assessed R50's skin. R50's skin was normal pink in color, free of any unusual warmth or swelling, there were no reddened areas, and her skin was fully intact. RN-B also said R50 was incontinent of urine. R50 had not been repositioned from 7:55 a.m. to 11:12 a.m., a total of 3 hours and 7 minutes.

During an interview on 7/23/2015 at 11:16 a.m., nursing assistant (NA)-F stated R50 was last repositioned when she was put in her wheel chair "at about quarter to eight." NA-F then stated R50 was on an "every two hour repo [repositioning] schedule," and R50, "Was definitely ready to be repositioned."

A review of nursing and physician long-term care progress notes from 3/26/2015 to 7/14/2015, indicated R50 did not have, nor was being treated for a current pressure ulcer. During this time, R50 did not develop a pressure ulcer.

In an interview on 7/23/2015 at 4:00 p.m. registered nurse (RN)-A stated she would consider any resident "who had a stroke to be at risk for pressure sores." RN-A also said she would "look at everything" to determine if a resident was at risk to develop a pressure ulcer. RN stated R50 scored "a 13 on the Braden" (a measure for predicting pressure ulcer risk), but that also R50 "had immobility, incontinence, and

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F 314	Continued From page 58 other risk factors" and was "at risk for pressure." RN-A said she trusted the work group on the floor to get toileting and repositioning completed, but what happened today, "I'll say was a fluke." RN-A also stated, "I'll be honest, she should have been turned." During an interview on 7/27/2015 at 1:19 p.m., the director of nursing (DON) said the nurse manager had already taken steps to avoid issues when a resident is on a schedule to be turned and checked for incontinence. The DON said in this instance, "[R50] should not go right from breakfast into other activities, that is too long." The DON said resident interventions were care planned, and the facility takes "very seriously, residents' needs for timely assistance." A facility policy, Treatment and Prevention of Skin Breakdown and Ulcers, reviewed 3/14, indicated "It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity..." and "implement preventive measures..." Further, the policy directed, to "establish and record an individualized turning and repositioning schedule if the resident is immobile."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	F 315		

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infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide timely toileting assistance for 1 or 1 residents (R50) who had urinary incontinence.

Findings include:

R50's diagnoses, as identified on the care plan (CP), reviewed 6/6/2015, included hemiplegia affecting dominant side, dementia, and aphasia due to cerebrovascular disease. The quarterly Minimum Data Set (MDS), dated 5/27/2015, indicated R50 had severely impaired cognition, and was unable to walk. The MDS also identified R50 required extensive, physical assistance for activities of daily living (ADLs), including two-person assist with bed mobility, transfers, toileting, and personal hygiene. A bowel and bladder assessment, dated 2/25/2015, indicated R50 was incontinent of bowel and bladder, and also was not safe to use a commode or toilet due to poor trunk control. Further, the assessment indicated R50 would "be checked for incontinence q 2hr [every 2 hours] and peri care given after each incontinence episode." The care area assessment (CAA) for urinary incontinence, dated 3/11/2015, indicated R50 had dementia, and past history of cardio-vascular accident (stroke), with right-sided hemiplegia. The CAA also indicated R50 was not a candidate for retraining.

R50's CP identified alteration in elimination/toileting, that she was incontinent of

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bowel and bladder, and also that R50 was not using the bathroom due to safety. The CP directed staff to assist R50 "to check and change every 2 hours and PRN" [as needed]. The nursing assistant care sheet "North" unit, undated, also directed for R50: Check and change q 2hrs and PRN [every 2 hours and as needed].

During continuous observation on 7/23/2015 from 7:55 a.m. to 11:12 a.m. (3 hours and 7 minutes) R50 was observed to be dressed and seated upright in her wheel chair, with her right hand and wrist fitted with a splint device, and her right arm was supported and strapped into the arm rest. At 7:55 a.m., R50 was seated in her wheel chair in the living area across from the north unit nursing station and watching a news program on TV. At 8:33 a.m., R50 was wheeled into the dining room and assisted with breakfast, finishing at 9:36 a.m. Following the meal, and still seated in the wheel chair, R50 was moved from the table where food was served to the activity area in the same room. R50 participated in the morning activity, and stayed in the activity area until just after 10 a.m., when a staff member wheeled her into the main entryway of the facility. R50 remained there, still seated in her wheel chair, until 10:19 a.m., when a staff member pushed R50 outside of the building, joining other residents to get fresh air. At 10:37 a.m., R50 was returned into the building near the aviary, and approached by nursing assistant (NA)-F, who after greeting R50, took her vital signs. More than 2 1/2 hours had elapsed since the initial observation, and still R50 was not off loaded, or repositioned out of her wheel chair. R50 remained seated in her wheel chair near the aviary until 11:12 a.m., when NA-F assisted her back to her room. In her room,

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NA-F and registered nurse (RN)-B, using the mechanical lift, assisted R50 into her bed. R50 was incontinent of urine, and NA-F provided cleansing cares for her. In the presence of the surveyor, RN-B inspected and assessed R50's skin, and also said R50 was incontinent of urine. R50 was not assisted for toileting from 7:55 a.m. to 11:12 a.m., a total of 3 hours and 7 minutes.

During an interview on 7/23/2015 at 11:16 a.m., nursing assistant (NA)-F stated R50 was last repositioned when she was put in her wheel chair "at about quarter to eight." NA-F then stated R50 was on an "every two hour repo [repositioning] schedule," and that R50 should also be checked for "urinary incontinence."

In an interview on 7/23/2015 at 4:00 p.m. registered nurse (RN)-A stated she would consider resident "who had a stroke to be at risk for pressure sores." RN stated R50 scored "a 13 on the Braden" (a measure for predicting pressure ulcer risk), but that also R50 "had immobility, incontinence, and other risk factors" and was "at risk for pressure." RN-A said she trusted the work group on the floor to get toileting be completed, but what happened today, "I'll say was a fluke."

During an interview on 7/27/2015 at 1:19 p.m., the director of nursing (DON) said the nurse manager had already taken steps to avoid issues when a resident is on a schedule to be turned and checked for incontinence. The DON said in this instance, "[R50] should not go right from breakfast into other activities, that is too long." The DON said resident interventions were care planned, and the facility takes "very seriously, residents' needs for timely assistance."

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F 315	Continued From page 62 A facility policy, Bowel and bladder Program Policy, revised 3/14, indicated as its purpose to "Maintain resident's optimal bowel and bladder continence and maintain skin integrity The policy indicated individual care plan will address "Times to toilet based on individual schedule and/or checking for incontinence."	F 315		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure exhaust fan duct work, lights above grill and screen in the kitchen were clean of dust and debris. This had potential to affect all residents, staff and visitors who consumed food from the kitchen. Findings include: During the initial tour of the facility kitchen with registered dietician (RD) on 7/20/15, at 1:15 p.m.; six metal caged lights above the grill where the food is cooked, were covered with 1/4 inch visible thick dust and debris from the light fixtures. In addition there was a 12 inch long by 6 inch window screen above the kitchen sink which was completely covered in a black dust and debris. An additional tour was completed on 7/21/15, at	F 465		

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F 465	Continued From page 63	F 465		

7:30 a.m. the lights and screen were still observed to be covered with visible dust and debris.

During interview 7/21/15, at 8:15 a.m. dietary manager (DM) stated the lights were covered in dust along with the screen; the maintenance department was in charge of cleaning these items. The DM stated the maintenance has a staff of 5 and 3 of them are on light duty so things just are not getting done.

During interview 7/21/15, at 8:30 a.m. the maintenance manager (MM)-A stated they have a contracted service that cleans the overhead hood vent two times a year. The maintenance director did inspect the lights and the screen and stated "That doesn't cut it" and expressed it is still the expectation to complete needed tasks.

Review of the facility contracted cleaning service document form Fire Protection Equipment Co. After Service Follow Up Report dated 9/22/14, indicated the kitchen exhaust system hood was cleaned but not to code due to them being inaccessible. The recommendations indicated to "replacing box-style fan with upblast style to better access duct work." The company was out again on 3/2/15 and the Fire Protection Equipment Co. After Service Follow Up Report recommended "replacing box-style down blast fan with upblast fan to access fan and duct work. Replace damaged filters."

During interview 7/22/15, at 2:00 p.m. the MM-A stated the "fan blows down and then diverts the air up to create a vacuum up and out of the roof". The MM-A stated the fans should be cleaned, but that is how this style exhaust fan works and it is

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F 465	Continued From page 64 grandfathered until we remodel the kitchen at some uncertain time. During phone interview 7/22/15, at 2:15 p.m. with representative from the Fire Protection Equipment Co. stated the fan and ducts are inaccessible because they were unable to see down to the bare metal. The system was very old, which was probably manufactured in 1960's or 70's, and recommended a new unit. The facilities Nutritional Services Cleaning Procedure Equipment Hood policy undated indicated 1. the inside and outside of the hood will be cleaned once per month 2. clean the inside and outside of the hood 3. clean the light fixtures within the hood. Remove the light fixtures and clean with soap 4. use a brush or cloth as needed to remove grease and/or dust 5. wash hood with soap and water 7. the interior section of the hood that extends to the roof is cleansed semi annually by a commercial hood-cleaning operator.	F 465		

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An extended survey was conducted by the Minnesota Department of Health on 7/27/2015	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure safe self-administration of medications (SAM) for 1 of 1 residents (R63) observed for self-administration of a nebulizer treatment. Findings include: During observation on 7/20/15, at 7:28 p.m. R63 was observed alone in her room with a nebulizer (a drug delivery device used to administer medications in the form of a mist inhaled into the	F 176	R-63 with the Potential to Affect all residents who have orders to receive nebulizer treatments. 1. On 7/28/15 TMA-A was coached on Self administered nebulizers vs not self administered nebulizers. She was also given the policy on Self-administered medication. 2. On 8/12/15 The MAR of all residents who have an order for Nebulizer treatment were updated to indicate if they have met the	8/13/15

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

Electronically Signed | 08/21/2015

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F 176	Continued From page 1 lungs) running, with a face mask. The trained medication aide (TMA)-A who had administered the medication was on the opposite side of the dining room passing medications and assisting other residents in their rooms. R63 removed the mask off her nose and mouth and placed the mask on her chest with the elastic strap still around the back of her neck. TMA-A walked past R63's room while R63 had the mask on her chest and into the room next to R63 twice. TMA-A made no attempted to check, or reapply the mask to R63's nose and mouth for installation of the medication. At 7:44 p.m. TMA-A entered R63's room, turned off the nebulizer and removed the mask from R63's chest. R63's diagnoses included dementia with behavioral disturbances, depression, anxiety, chronic obstructive pulmonary disease (COPD) and congestive heart failure. A cognition care plan dated 6/2/15, indicated R63 was disorientated to time and place and had moderately impaired cognition. The Physician's Orders and the Medication Administration Record (MAR) for 7/15, directed Duoneb to be administered four times a day. A hand written note on the MAR indicated R63 did not like the nebulizer mask and to hold the mask in front of her face and let her breathe in that way. A Self Administration of Medication Assessment effective 7/21/15, indicated R63 was not cognitively able to participate in a SAM. During interview on 7/20/15, at 7:50 p.m. TMA-A stated she did not know if R63 could be left alone with the nebulizer. TMA-A added she usually does not leave residents alone with their	F 176	requirements allowing to self administer their Nebulizer treatment. 3. On 8/13/13 An email was sent to all nurses regarding the administration of self-administered medication. Any Resident that is allowed to self administer their nebulizers will be noted in the MAR, If this is not noted the nurse must REMAIN with the resident during the treatment. A memo was placed on each Medication Cart. Monitoring 1. Starting 8/24/15-9/28/15 An audit will be completed on a minimum of 5 residents who have scheduled Neb. treatments every day x1 week, then every week x 4 weeks to ensure all residents who do not have an order to self administer medication are being observed during the treatment (Attachment A) Responsibility Parties: Care Coordinators or DON Audit reports will be reported to the Quality Assurance Committee. (QA meets quarterly; Oct., Jan., April and July).	

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F 176	Continued From page 2 nebulizer but because it had been so hectic and busy she left R63 alone. On 7/23/15, at 11:20 a.m. registered nurse (RN)-A stated R63 was assessed to not to be left alone to SAM the nebulizer. In the past she would not even allow the mask but now will allow staff to hold the mask in front of her.	F 176		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225		8/21/15

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F 225	Continued From page 3 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure all allegations of abuse, neglect, mistreatment and injuries of unknown were immediately reported to the adminstrator and state agency, were thoroughly investigated, and residents were protected during their investigations for 8 of 15 residents' (R47, R12, R22, R39, R11, R66, R44 and R8) allegations reviewed. The facility failed to conduct reference checks for 4 of 5 newly hired employees (NA-A, NA-B, DA-A and RN-B). Findings include: Investigation and Protection During interview 7/23/15, at 5:09 p.m. with social worker (SW) stated that nursing assistant (NA)-C has been implicated in four incident reports from January 2015 to July 2015 as the potential alleged perpetrator (AP). Review of facility Incident and Investigation reports indicated the following: R47's quarterly Minimum Data Set (MDS) dated 2/17/15, indicated she was moderately cognitively	F 225	Investigation and Protection: Affects residents R47, R12, R22, R39, R11, R66, R44, R8 with the Potential to affect All Residents. Injuries of Unknown Origin: Affects residents R39, R11, R66, R44, R8 with the Potential to affect All Residents. Corrections support investigation, protection and injuries of unknown origin 7/24/15 @ 10:35 PM: A Performance Improvement Plan was delivered and implemented effective immediately with NA-C. (Attachment B). One said measurement included NO complaints regarding care action during the shift. Failure to meet this goal will result in further disciplinary action up to termination. 7/29/15 In order to ensure the protection and safety of R22 it was decided that at this time 2 staff would be required in the room when providing care. This was discussed at R22's Care Conference and was approved by both R22 and her family.	

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F 225	Continued From page 4 intact and needed extensive assistance in ADLs. R47's care plan dated 2/26/15, indicated she had dementia and needs assist with dressing, grooming and bathing. The care plan further indicated she had slight alteration in cognition related to dementia and that resident will continue to be oriented to person, place and time. Mille Lacs Nursing Home Progress Notes dated 1/24/15, at 3:49 a.m. indicated: "This nurse [LPN-D] was in a res. room, 5 rooms away from where the incident happened, but heard a distinct smack. Followed by a woman's out cry. This nurse then got a call on the walkie [walkie-talkie] from the aide. The aide stated (in her words) On 2 a.m. rounds, I went to check resident in room 45-1 and woke up resident in 45 -2 [R47] in the process. I told [R47] the time and said she should lay back down and try and get some sleep until coffee time. [R47] said "No, I want to sit up I'm waiting." NA-C said "No lets lay down" and NA-C went to pick up [R47's] feet to bring them in bed and [R47] swung and hit me in the head, fairly hard. I [NA-C] yelled out "ow" and NA-C said "why did you hit me, R47 said "I didn't, you hit me you liar" then [NA-C] walked out and walkie the nurse...." This nurse [LPN-D] asked the res. why she hit the aide. Res. [R47] stated that the aide hit her." An Incident Report submitted to the state agency on 1/28/15, indicated that R47 had a conflict with a nursing assistant on 1/24/15. Following a review of the related progress notes, and supervisory staff, it was originally determined R47's incident was due to her dementia. Further study revealed that R47 allegedly struck a nursing assistant, but resident [R47] also alleged the nursing assistant struck her. The report indicated	F 225	8/15/15 Existing VA tracking log revised to include identity of alleged perpetrators to better identify trends occurring, including those incidents that have been ¿unable to substantiate.¿ The Log will be updated at the time investigation results are submitted to OHFC and again when the investigation is closed. Upon Closure of each incident the VA Log will be electronically forwarded by LSW to administrator to assure the administrator is kept informed of the FULL STATUS of the investigations with regards to timeliness of report submissions, final disposition and actions taken with regards to alleged perpetrator. Person(s) responsible: LSW On 8/17/15: Facility wide Vulnerable Adult Policy (Attachment C) revised to delineate protections for residents This includes CMS language defining injuries of unknown source. On 8/18/15: Administrator and Medical Director sent a letter (Attachment D) to all residents and/or their representatives regarding survey findings; how, what and how often we educate staff and the facility¿s commitment to protecting vulnerable adults. A flier with information on warning signs of abuse and neglect, and a copy of the staff education over the last 12 months were included with the letter. On 8/19/15 Social Service Incident Reporting Form (Attachment E) was	

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F 225	Continued From page 5 a further investigation needed to be completed. A follow-up Investigative Report was submitted to the state agency on 2/2/15. The report indicated the SW met with the resident R47 on the a.m. of 1/28/15 and 1/30/15 and resident was unable to recall any incidents of concerns. The SW was unable to speak with NA-C until 2/2/15 (7 days after the SW learned of the situation) in part due to her work schedule not coinciding with the SW. SW spoke with NA-C by phone on 2/2/15, at 10:45 p.m. NA-C acknowledged the incident happened as described by LPN-D's note. NA-C stated she had not struck R47 in any way, but had tried to lift R47's legs to help her lay down. The investigative report indicated the AP was NA-C. This report also included that NA-C had been implicated in a previous submitted report. During interview 7/23/15, at 5:10 p.m., the SW stated the resident was unable to recall if the incident had happened, and said R47 had dementia. The SW said NA-C was not suspended during her investigation because it could "not be proved" that NA-C abused R47, and R47 continued to be on the work schedule. The SW said NA-C was counseled on how to provide cares for R47, and was asked for ideas from NA-C on how to keep R47 safe. Review of the facility's MLHS-LTC NA/R Schedule indicated NA-C was not suspended pending the investigation of the incident dated 1/28/15 and NA-C was scheduled to work 1/28/15 and 1/29/15, while the investigation was in progress. The investigation of this incident lacked timely interviewing of the NA-C. This incident occurred	F 225	revised to provide documentation space that clearly identifies the initial evaluators thoughts in regards to: 1) Reason for submission 2) Rationale for NOT submitting report beyond the facility 3) Action taken to Protect The Resident The revision also provides the review team a means to clearly document their evaluation of the incident and any ACTION that they feel needs to be taken on but not limited on the following items: (Attachment F) 1)Timeliness of the report 2) Was Protection of the resident appropriate 3) Reportability decisions were appropriate The vulnerable adult reporting process/guides located at each nurses' station will be updated by 8/25/15. Responsible Person: LSW 8/19/15: 4- separate staff meeting were scheduled for 8/25/15 where the Administrator, DON and LSW will jointly provide nursing staff with training regarding the up to date changes that have been put into place to assist staff in identifying potential abuse and neglect, protecting the resident, discerning reportable injuries of unknown origin and reporting requirements. This staff mtg will also cover the revisions to policies and available tools. All Nurses and NA-R staff will be strongly encouraged to attend, an attendance record will be kept	

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F 225	Continued From page 6 on 1/24/15 but was not reported to the SA until 1/27/15. The investigation did not determine if the R47 was actually abused. The facility did not suspend NA-C or take action to protect residents, during the investigation. There was no indication that a thorough investigation was completed for R47. R47 had another facility Social Service Incident Referral Form (SSIRF), signed by RN-C indicated R47 was involved in an incident on "3/2/15 early a.m., of possible abuse or resident aggression." The SSIRF indicated: RN-C noted PCC notes (electronic progress notes) by LPN-B questioning verbal statements and other behaviors by resident [R47]; possible indication of maltreatment but just a likely symptoms of resident's dementia." The SSIRF further indicated the incident was discussed with Investigative Team on 3/3/15 at 8:30 a.m., and reported submitted to the state agency on 3/3/2015 at 12:30 p.m. The report also indicated NA-C was a person with credible knowledge of the situation. An initial Incident Report was submitted to the state agency on 3/3/15 regarding possible abuse of R47 on 3/2/15. The report referenced "two progress notes from NOC (night) shift early that a.m. of 3/2 that suggests either some behavioral concerns/dementia symptoms by resident [R47] at work or possible maltreatment of resident by staff." The report indicated uncertainty by staff on whether this was maltreatment, and "SW decided to go ahead and submit the allegation to [state agency]...." A nursing progress note, dated 3/2/215 at 4:03	F 225	and those staff unable to attend will be required to review materials presented and minutes of the meeting. A signature of completion will be required at the time of the review but no later than 9/1/15. Persons responsible: Administrator, DON and LSW 8/20/15: Protection of the Residents After review of all final evidence in the 2567 report NAR-C will be terminated 8/21/15. (NAR -C has been off since 8/10/15, earliest available meeting date for NAR-C prior to next scheduled shift is 8/21/15). (Attachment G) MONITORING 1. Audit (Attachment H) of each Social Service Incident Report Form will be reviewed for: timeliness of reporting, appropriateness of report, and actions taken to protect residents The audit will begin with any incident occurring after 8/21/15 and will include every incident reported for the next 3 months (ending 11/21/15) Responsible person: DON and LSW . Audit (Attachment I) of each Investigation Report will be completed to:Ensure thoroughness of investigations. The audit will begin with any incident occurring after 8/21/15 and will include every incident reported for the next 3 months (ends 11/21/15) Person(s) responsible: DON and LSW Both audit reports will be reported to the Quality Assurance Committee. (QA meets quarterly; Oct., Jan.,April and July).	

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F 225	Continued From page 7 a.m., written by LPN-B, indicated [R47] was "kicking at staff" and [R47] told staff "she was going to report 'her' to the nurse.." The note also indicated R47 told staff "you go around hitting everyone I heard.." On 3/2/15 at 6:03 a.m., a second progress noted indicated staff went to wipe dry blood off [R47's] lip, and [R47] hit staff. The note continued, that after R47 hit staff, R47 stated "I am going to report you for hitting me." Facility documentation did not indicate any action was taken to protect R47 and other residents during this investigation of potential abuse. Documentation of the investigation of this incident did not include determination the cause of R47's bloody lip, and there was no evidence of interview with the nursing assistant who provided cares for R47. The SSRIF also indicated there was no immediate reporting of this incident to the state agency or administrator. A final, Investigative Report was submitted to the state agency on 3/06/15 regarding the incident. The report indicated on 3/2/15 the "resident was interviewed by RN Care Coordinator (RN- A) and this SW. Resident denied remembering anything happening this past weekend during the daytime or the nighttime that upset her in any way.....She denied that anyone hits her or has been mean to her or that she has hit anyone else." The report also indicated "SW communicated with [LPN-B] about progress notes from 3/2/15 during night shift, "indicating the NAR was situating resident in the EZ lift (mechanical lift) to help her to the bathroom per resident's request and the NAR noticed resident's lip had been bleeding apparently cracked from being chapped with dry, winter air. [NA-C] told [R47] she was going wipe the dried blood off, but R47 struck out at NA,	F 225	Reference Checks: F225 (completed 8/19/15) Affects Residents R47,R12,R22 R39, R11, R66, R44, R8 and the Potential to affect all Residents 1. 8/18/15 The VA policy was updated (attachment C) indicating that HR would attempt to obtain information from previous employers and /or current employers during the pre-employment screening process including dates of employment, position held, and feedback on workplace performance 2. 8/18/19 A new Reference Check Form was developed (attachment J) which identifies documented reference checks with dates of employment, position held and feedback on workplace performance. 3. 8/18/15 The VP of HR provided Training to the HR recruiter on the revised VA Policy, and the new Reference Check Form. The Reference Check Form was implemented on 8/19/15 and will be used on all new hires going forward Monitoring: (attachment K) Responsible Party: VP of HR 4. Biweekly audits will be completed by the VP of HR or designee for for all new hires. The audit will include verification that the Reference Check form was completed for all new hires prior to their first day of employment. Audit reports will be reported to the Quality Assurance Committee.	

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F 225	Continued From page 8 causing NA's glasses to dismount from her face." The report indicated NA-C re-approached later and assisted [R47] without incident. Later the same night, the NA was doing rounds and attempted to lift R47's feet back in bed, and resident kicked at NA-C. The report then referenced the allegations made by R47, that she was slapped. The report did not confirm a perpetrator in this incident. The report indicated R47's care plan was reviewed, and suggestions were made on how to approach R47 during cares. The report also indicated LPN-B was coached by the SW and DON on more thorough progress note charting, and further, that staff have been reminded to submit timely incident reports. The report included: "Something is just not resting well with this, and although there is no maltreatment of residents 'substantiated' in this particular incident, SW will continue to keep eyes and ears open for patterns and/or trends in conduct, etc." Review of the facility's MLHS-LTC NA/R Schedule from February 23, 2015 to March 8, 2015, indicated NA-C was assigned to work 3/2/15 (the night of the alleged incident) and also worked on 3/3/15. During interview 7/23/15, at 5:30 p.m. the SW stated, in review of this incident, she had "concerns with NA-C" but again could not prove she had really done anything wrong. The facility felt they could not substantiate the allegations against NA-C, and therefore did not warrant a "suspension or discipline" during the investigation. There was no indication that a thorough investigation was completed for R47.	F 225	(QA meets quarterly; Oct., Jan., April and July).	

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R12's quarterly MDS dated 4/27/15 indicated she was moderately cognitively intact and needed extensive assist with dressing, bathing and grooming. R12's care plan dated 1/31/15, indicated she had potential for abuse from others related to cognitive impairment and limited mobility.

An initial Incident Report submitted to the state agency on 2/18/15, indicated that on 2/18/15, R12 was allegedly slapped, on her cheek, by a staff person who was attempting to administer medicine. The AP on the Incident Report was listed as unknown.

A final Investigative Report was submitted to the state agency on 2/23/15, regarding the incident. The report indicated R12 had made numerous allegations, but the only allegation that could be "tracked," was the one about someone slapping [R12] during the administration of Milk of Magnesia (MOM) that morning. Firstly, the report indicated the SW and DON proceeded to seek more information about who would have administered the MOM that morning. Per schedule, LPN-B and NA-C were the persons on duty. At 10:45 p.m. on 2/19/15, the DON and SW met with NA-C, who freely admitted having given MOM to R12 under direction of LPN-B. NA-C said "[R12] didn't want the MOM, and [R12] took the cup and threw the MOM all over." [NA-C] tried to clean it up off the bedding, resident's clothing and her face, using wet wipes." The report indicated NA-C denied slapping R12 in any way, but acknowledged wiping R12's face off with the wet ones. The report indicated, "It is possible this was perceived by [R12] as a slap." The SW asked NA-C to go to resident's room to see if resident could/would or would not identify

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her as the lady who slapped her, and NA-C agreed to do so. [R12] was sleeping soundly, however, so decided not awaken her. The report indicated "[NA-C's] willingness to go, however, leads SW to believe she [NA-C] is being truthful about not slapping resident." The report then indicated the DON spoke to LPN-B by phone on 2/23/15 at 3:20 p.m. LPN-C admitted asking NA-C to give MOM to R12 due to LPN being occupied elsewhere LPN-C also acknowledged that NA-C did report [R12's] claim of being slapped by a "blonde lady." The report then indicated staff have been alerted to have two persons present during cares with this resident and NA-C was instructed not to enter room without a colleague present.

During interview on 7/23/15, at 5:20 p.m. the SW stated she did not suspend NA-C since they could not prove NA-C slapped R12. The SW acknowledged NA-C had been involved in multiple incidents, and had "suspicions" with [NA-C], but did not feel "there was a reason to suspend" or provide disciplinary action to her during this investigation.

The investigation of this incident by the facility did not determine if R12 was slapped, nor was there follow up to have R12 positively identify the nursing assistant who provided cares. Although NA-C was instructed not to enter R12's room without a colleague present, the documentation offered no indication protections were put in place for other residents who were assisted by NA-C during this investigation of this incident, regardless of its outcome.

R22's admission MDS dated 4/24/15, indicated

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she had depression and a cerebral vascular accident (CVA), was moderately cognitively impaired and needed limited assist with transfers and extensive assist with toileting. R22's care plan dated 5/3/15, indicated she needed assist with toileting and transfers, had history of depression and sadness/isolating self. R22's care plan further indicated she had potential for abuse from others related to her general weakness, aches and pains. The care plan goal indicated "resident will remain safe and have needs met in a safe environment."

During observation on 7/20/15, at 5:54 p.m. R22 lifted her pant leg and displayed a bruise on her right shin measuring approximately 8 cm (centimeters) x 2 cm.. R22's bruise was black, fading to dark purple in color, with no apparent swelling

In an interview 7/20/15, at 5:54 p.m. R22 stated that she had been treated "roughly by the staff" and there is a staff member who works the night shift that is rough with her. R22 went on to state this staff member had "grabbed her arm when transferring" which caused a large bruise and also stated she had also hit her leg into the metal bar along the bottom of her bed.

The facility submitted an Incident Report to the state agency on 6/27/15, regarding an incident of alleged mistreatment and physical abuse of R22. The report also identified a bruise on R22's top right hand, measuring 5.5 cm x 5 cm, circular in shape; and a second bruise on R22's lower right shin 2.5 cm x 2.5 cm, circular in shape. The report was submitted by RN-D, and indicated that the initial reporter, NA-A, was also the alleged perpetrator in this incident. The report indicated,

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nursing assistant (NA)-C reported at 5:15 a.m., she had toileted R22, After being toileted, R22 told [NA-C] she was not coming back tonight,and that "some girl hurt her." NA-C asked who, and she [R22] stated she doesn't know who. The report then indicated that registered nurse (RN)-A, followed up with R22 in the morning and asked her to tell her what happened: "Resident reported she is not staying here again tonight and is not going to be treated like this anymore." R22 explained that staff was mad at her during the night for getting up to use the bathroom so many times, and that a "girl grabbed me and threw me into bed." R22 pointed out her hand hurt, and said "this is where she grabbed me," noted a bruise on top of right hand measures 5.5 cm (centimeters) x 5 cm circular is shape. R22 also reported when she threw me into bed, "I hit my leg on something metal;" a bruise noted on right outer lower shin measures 2.5 cm x 2.5 cm circular in shape. R22 could not recall who the girl was, nor her name. R22 thought it was around 0400. The report further indicated NA-C was the nursing assistant working on that wing during the night, and LPN-A was the nurse in charge. No other injuries noted, resident was reassured she will remain safe here, NA-C will be removed from working with resident at this time.

An additional Incident Report was submitted to the state agency on 7/1/15, which identified an injury of unknown source on R22's right forearm 8 x 5 cm, reddish purple in color, and oval in shape. The date of incident occurrence was unknown. The report indicated R22 said, "It happened a few days ago."

An Investigative Report was submitted to the state agency on 07/02/15, which combined the

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two submitted incident reports. The report indicated the DON and social worker SW "have tried to investigate this issue thoroughly and have been unable to substantiate who the alleged perpetrator [AP] is for certain, but have reached a conclusion there is reasonable suspicion a crime may have occurred in the form of assault, and are hence submitting a report also to law enforcement, in accordance with Elder Justice Act." Further, "The details of our internal investigation to the limits of our ability are being submitted to OHFC [Office of Health Facility Complaints] the state agency." The Investigative Report further indicated on 7/1/15, the DON and SW met with the AP, (NA-C) who stated R22 had requested to use the toilet 6-8 times that night (6/27/15). The report then indicated [SW and DON] "discussed with the AP the number of previous incidences involving this NAR, which can raise red flags re [regarding] her credibility, and she became somewhat defensive, face reddening and voice tightening, saying 'it's because I report things and others don't, so I end up getting in trouble.'" The report further listed, that during an interview 7/2/15 the DON and SW meet with NA-D, who stated she "reported having heard from resident (R22) on 6/30, that [R22] is afraid of the girl with the blonde hair and bangs, that she is not very nice, etc. The blond hair with the bangs fits description of NA-C. The report further included that NA-C had been "implicated in previous reports 75814, 78740, and 79433 with possible "power struggles" with residents, as she tries to perform cares; received coaching in these incidents. NA-C was also involved in report 79866 but was not specifically named as AP."

Although R22 had described NA-C as the staff member who had hurt her and NA-C was caring

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for her and received multiple large bruises, no disciplinary action was taken, NA-C was not suspended pending the investigation. Also, there was no indication that a thorough investigation was completed by the facility to include other interviews with staff and residents.

During interview on 7/23/15, at 4:50 p.m. the DON stated she has concerns that NA-C might be doing the accusations, but stated she was not certain. The DON said, "Staff monitor [NA-C] during the night shift," and "we have nurses on that do that." The DON stated the nurses were to report if they notice anything and have concerns.

In an interview on 7/23/15, at 5:03 p.m. the SW stated she did not talk with other residents or staff regarding abuse allegations by R22. The DON stated, "I don't generally do that, it's not a witch hunt." The DON said, "Just because their name keeps coming up does not make them guilty." The DON also said there were issues around "data privacy and confidentiality." SW further stated when something regarding abuse allegations come up over the weekend, the nurse on duty initiates the OHFC reporting. The SW said the nurse would talk to the resident, and address any immediate concerns. Regarding NA-C, the SW stated, "At times there have been several residents she is not allowed to care for, but that does change if, during the investigation the allegation is not substantiated." The SW further stated, in regard to NA-C, after the first allegation of abuse, "a lot of coaching was done." The SW also said the coaching for NA-C was "not intensive, and there was no improvement plan initiated and no documentation of education or mentoring done."

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During an interview on 7/23/15 at 5:10 p.m., the administrator said, "We have three young people working on nights, we can't suspend; there is not enough staff." The administrator further stated, " I feel the DON and SW did the right thing."

During an interview on 07/23/15, at 5:14 p.m. the DON stated NA-C was not suspended per the facility policy following the allegation made by R22 . She stated, "If I had suspended one, I would have had to suspend all three staff, then who would take care of the residents?"

During an interview on 07/24/15, 5:14 a.m., NA-E stated, " I don't work a lot of overnights unless I am mandated, but I do hear a few things." NA-E stated, "I have heard about people being super wet and I have heard that some of the girls are a little rough, but I can't tell you who." She further stated one of the residents mentioned about a girl being rough and leaving bruises. NA-E described the staff member as they were described by the resident and stated the resident said " the girl threw me into the chair because I had to go to the bathroom again." NA-E stated she does not see the nurse a lot on nights.

During interview on 7/24/15, at 5:25 a.m. LPN-H stated she works part time on the night shift. LPN-H stated she has heard from other NAs that NA-C is rough with the residents but had not witnessed it directly. LPN-H stated she was not aware that she was to monitor any staff during the night shift when she works. She further indicated she had heard R12 had reported that NA-C had slapped her and that NA-C no longer works on the North wing and thought the reason was because of the cat; not because she can not take care of any certain residents. She then

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stated the aides on the night shift don't work together they prefer to work on each unit alone.

INJURIES OF UNKNOWN ORIGIN

R39's annual MDS, dated 3/9/15, indicated she was moderately cognitively impaired. Her care plan, dated 3/30/15, indicated she required extensive assist with all activities of daily living, used a mechanical stand for transfers, and was at risk for abuse related to dementia.

Review of Social Service Incident Report Form, dated 10/7/14, indicated R39 had a large, dark purple bruise on the right upper portion of her buttock and that R39 was unaware of how the bruising occurred. The report indicated R39 had been lowered to floor by staff a few days prior to the bruise and indicated that may have caused the injury. The incident further indicated use of anticoagulant medication (used to prevent clotting) , other injuries/incidents over an unspecified times frame, and listed the injury as "minor." The injury was not reported to OHFC.

During an interview on 7/24/15, at 12:54 p.m., the DON)stated, when R39 had been lowered to the floor it would be hard to know if injury occurred during that event but stated, R39 bruised easily due to use of anticoagulant medication so therefore the injury was not considered reportable.

Although R39 was moderately impaired and unable to recall how the bruise occurred, there was no evidence that a more in-depth investigation was completed to determine the

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actual cause, nor was R39's injury of unknown origin reported to the state agency.

R11's quarterly MDS, dated 4/15/15, indicated she was moderately cognitively impaired. Care plan, dated 6/3/15, indicated R11 required extensive to total assist for all activities of daily living, was cognitively impaired, and at risk for abuse related to depression.

Review of three separate Social Services Incident Report Forms indicated R11 had injuries of unknown origin. An incident form dated 10/21/15, indicated R39 had a bruise to the top of her right hand that was dark purple in color and measured 8 cm x 8 cm. The report further indicated R11 was unable to state how the injury occurred, used blood thinners and described the injury as "minor." Another Social Services Report Form, dated 11/4/14, indicated R11 had bruising noted to her left temple and above her left eyebrow, and was unable to state the cause of the injury. A third incident report dated 12/18/14, indicated R11 had a bruise of unknown origin to her left inner knee, dark purple in color, measuring 1 x 1 3/4. (unit of measurement was not indicated). The report further indicated R11 was unable to report the cause of the injury, use of anticoagulant medications, and the injury was considered to be " minor." None of the three bruises were reported to OHFC.

During an interview on 7/24/15, at 12:54 p.m., SW stated, R11 "had more bruising than anyone I have ever known." She stated the bruise on R11's hand may have been caused by "recent trimming of [R11's] nails." Regarding the bruise noted to

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R11's temple and forehead, SW stated that nursing felt the bruising was due to placement of R11's nebulizer mask, however, SW interviewed R11 who reported that she slipped and fell on her way back from supper. SW further stated R11 did not ambulate, used a Hoyer lift for transfer and there were no records of any falls and indicated the bruising was likely due to placement of R11's nebulizer mask.

During an interview on 7/24/15, at 12:54 p.m., the DON stated R11 could reliably answer when asked if bruising was related to abuse, therefore, she felt the injury was not reportable.

Although R11 was identified to be moderately cognitively impaired, and had multiple bruises at different locations, and were unable to determine what happened, there was no indepth investigation completed to determine the actual causes of R11's bruises. The facility administrator was notified but none of these incidents were submitted to the state agency.

R66's quarterly MDS, dated 1/7/15, indicated she was moderately cognitively impaired. Care plan, dated 2/9/15, indicated R66 required extensive assist of two staff with use of mechanical lift for transfers, at risk for delirium, and at risk for abuse related to depression.

During review of a Social Service Incident Referral Form, dated 2/3/15, a facility progress noted indicated R66 had bruising along both arms from her hands to her shoulders. The form further indicated R66 was unable to state the cause of the injury and that the injury was assessed to be "minor." The injury was not reported to OHFC.

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During an interview on 7/24/15, at 12:54 p.m., SW stated, the bruises were noted while the DON was reviewing a progress note and she spoke with nursing and determined the bruising was assessed to be a minor injury and therefore not reportable to to OHFC.

During an interview on 7/24/15, at 12:54 p.m., the DON stated, R66 used a Hoyer lift (mechanical lift) and did not always cooperate in lift, occasionally "flailing her arms." She further stated, R66 was confused and that it would be "hard to say if R66 would have been able to to talk about how the bruising occurred after any time had passed."

Although R66 had bilateral bruising from her hands to her shoulders, the injury was unwitnessed and the resident was unable to identify what happened. The facility had not immediately reported the incident to the state agency nor was a thorough investigation completed to determine if R66 was "flailing her arms" while using the mechanical lift.

R44's annual MDS, dated 6/9/15, indicated she was severely cognitively impaired. Care plan, dated 7/10/15, indicated R44 required extensive assist with activities of daily living, and was at risk for abuse related to short term memory loss and impaired decision making skills.

Review of Social Service Incident Referral Form, dated 6/15/15, indicated R44 had a purple bruise on her posterior forearm measuring 6.3 cm x 7 cm that was found during her bath. The incident

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form indicated R66 did not state the cause of injury and that the injury was determined to be "minor."The bruise was not reported to OHFC.

During an interview on 7/24/15, at 12:54 p.m., SW stated, on 8/18/14, staff reported R8 had a bruise measuring 8.5 cm in length between her thumb and forefinger from the base of the thumb to her wrist. She stated the reporting nurse did the initial evaluation and determined the bruising resulted from R8 wringing her hands, and the wringing of her hands was witnessed by staff. She further stated the injury was not reportable due to staff witness of the potential cause. A Social Services Incident Referral form was requested for this injury but was not received.

During an interview on 7/24/15, at 12:54 p.m., SW stated when making a determination of whether or not to report an injury to OHFC, she refers to statutes, and uses a decision tree. SW also stated that she looks at whether a resident is able to explain the injury or if someone else saw it, and if there is a history of other recent falls and/or injuries. She further stated, if the nurses indicated minor injury or injury not suspicious in nature or location, it does not need to be reported.

During an interview on 7/24/15, at 12:54 p.m., the DON stated, there was no criteria for determining whether an injury was minor vs major. She further stated, the nurse finding the injuries did initial evaluation to determine the above injuries to be minor. The DON stated she would use the nurses judgement when determining if an injury was minor or major and that the RN in charge

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followed up on the injuries. However, she stated there was no charting in the clinical record that would show evidence that follow up had been completed.

Even though R44 was assessed to be severely cognitively impaired, had an injury of "unknown" origin, on the posterior of her arm. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency.

R8's quarterly minimum data set (MDS) identified her to be severely cognitively impaired and requiring assist of two staff for activities of daily living. CP dated 5/15/15 indicated R8 required extensive assist for activities of daily living and was at risk for abuse related to diagnosis of dementia.

A review of SSIRF dated 8/18/14, indicated R8 had a bruise measuring 8.5 cm in length between her thumb and forefinger from the base of her thumb to her wrist. The reporting nurse did the initial evaluation and determined the bruising resulted from R8 wringing her hands, and the wringing of her hands was witnessed by staff.

During an interview on 7/24/15, at 12:54 p.m., SW stated, the injury was not reportable due to staff witness of the potential cause. No further investigation of the injury was completed. The facility administrator was notified of the injury but a report was not made to the state agency. A Social Services Incident Referral form was requested for this injury but was not received.

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Although R8 had severe cognitive impairment, and had a bruise 8.5 cm between her thumb and forefinger from the base of her thumb to her wrist. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency.

Review of the facility Vulnerable Adult Policy, revised 7/15, indicated: "It is the policy of MLHS (Mille Lacs Health System) to protect adults who are vulnerable to abuse (including verbal, physical, mental psychosocial/emotional, and sexual abuse)..." The policy further indicated: "protection will include abuse prevention plans, individual abuse prevention plans, internal reporting of all cases of suspected abuse, neglect, or financial exploitation, and external reporting to the Common Entry Point (CEP) of substantiated incidents of maltreatment." In regard to investigation of a reportable incident, the policy stated: "All alleged violations are thoroughly investigated. The facility must prevent further potential abuse while the investigation is in progress." Under the "Protection for Resident or Patient" section, the policy directed that "The alleged perpetrator (AP) will be removed from the situation. If the AP is an employee, they will be suspended until the investigation is completed," and further, "Disciplinary action will be carried out up to and including dismissal of employee/employees as appropriate." The Policy defined Injury of Unknown Origin as "...source of the injury was not observed and injury as suspicious." The policy did not expound on this definition top include CMS definitions. In regard to screening of potential employees, the policy directed "MLHS will attempt to obtain information from previous employers and/or current

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F 225	Continued From page 23 employers."	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement their Vulnerable Adult Policy to ensure all allegations of abuse, neglect, mistreatment and injuries of unknown origin were immediately reported to the administrator and state agency, were thoroughly investigated, and residents were protected during the investigations for 8 of 15 residents' (R47, R12, R22, R39, R11, R66, R44 and R8) allegations reviewed. In addition, the facility failed to conduct reference checks according to their policy for 4 of 5 newly hired employees (NA-A, NA-B, DA-A and RN-B). This had the potential to effect all 50 residents who resided in the facility, and resulted in substandard quality of care under resident behavior and facility practices. Findings include: The facility Vulnerable Adult Policy, revised 7/15, indicated: "It is the policy of MLHS (Mille Lacs Health System) to protect adults who are vulnerable to abuse (including verbal, physical, mental psychosocial/emotional, and sexual	F 226	Investigation and Protection: Affects residents R47, R12, R22, R39, R11, R66, R44, R8 with the Potential to affect All Residents. Injuries of Unknown Origin: Affects residents R39, R11, R66, R44, R8 with the Potential to affect All Residents. Corrections support investigation, protection and injuries of unknown origin 7/24/15 @ 10:15 PM: A Performance Improvement Plan was delivered and implemented effective immediately with NA-C. (Attachment B). One said measurement included NO complaints regarding care action during the shift. Failure to meet this goal will result in further disciplinary action up to termination. 7/29/15 In order to ensure the protection and safety of R22 it was decided that at this time 2 staff would be required in the room when providing care. This was discussed	8/21/15

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F 226	Continued From page 24 abuse)..." The policy further indicated: "protection will include abuse prevention plans, individual abuse prevention plans, internal reporting of all cases of suspected abuse, neglect, or financial exploitation, and external reporting to the Common Entry Point (CEP) of substantiated incidents of maltreatment." In regard to investigation of a reportable incident, the policy stated: "All alleged violations are thoroughly investigated. The facility must prevent further potential abuse while the investigation is in progress." Under the "Protection for Resident or Patient" section, the policy directed: "The alleged perpetrator (AP) will be removed from the situation. If the AP is an employee, they will be suspended until the investigation is completed," and further, "Disciplinary action will be carried out up to and including dismissal of employee/employees as appropriate." INVESTIGATION AND PROTECTION During interview 7/23/15, at 5:09 p.m. with social worker (SW) stated that nursing assistant (NA)-C has been implicated in at least four incident reports from February 2015 to July 2015 of alleged abuse, and neglect. Review of facility Incident and Investigation reports from 2/1/2015 to 7/20/2015 for NA-C identified the following: R47's quarterly minimum data set (MDS) dated 2/17/15, indicated she was moderately cognitively intact and needed extensive assistance in ADLs. R47's care plan dated 2/26/15, indicated she had dementia and needs assist with dressing, grooming and bathing. The care plan further indicated she had slight alteration in cognition	F 226	at R22's Care Conference and was approved by both R22 and her family. 8/15/15 Existing VA tracking log revised to include identity of alleged perpetrators to better identify trends occurring, including those incidents that have been ¿unable to substantiate.¿ The Log will be updated at the time investigation results are submitted to OHFC and again when the investigation is closed. Upon Closure of each incident the VA Log will be electronically forwarded by LSW to administrator to assure the administrator is kept informed of the FULL STATUS of the investigations with regards to timeliness of report submissions, final disposition and actions taken with regards to alleged perpetrator. Person(s) responsible: LSW On 8/17/15: Facility wide Vulnerable Adult Policy (Attachment C) revised to delineate protections for residents This includes CMS language defining injuries of unknown source. On 8/18/15: Administrator and Medical Director sent a letter (Attachment D) to all residents and/or their representatives regarding survey findings; how, what and how often we educate staff and the facility¿s commitment to protecting vulnerable adults. A flier with information on warning signs of abuse and neglect, and a copy of the staff education over the last 12 months were included with the letter.	

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F 226	Continued From page 25 related to dementia and that resident will continue to be oriented to person, place and time. A facility Social Service Incident Referral Form (SSIRF) indicated licensed practical nurse (LPN)-D verbally reported to the social worker (SW) on 1/27/2014, at 4 p.m., an incident that occurred during the night shift on 1/24/2015. The SSIRF, dated 1/27/15, indicated: "Alleged altercation/conflict between res [resident] & aides resulting in resident slapping aide and stating 'I didn't hit you, you hit me you liar.'" The SSIRF also indicated, "LPN separated aide & resident, assisted res to bed, escorted aide to hallway to inquire what happened." The SSIRF also indicated the incident required "further investigation and/or reporting" to the state agency, and this was signed by the SW on 1/28/15. A review of Mille Lacs Nursing Home Progress Notes, dated 1/28/15, written by LPN-D indicated: "This nurse was in a res. room, 5 rooms away from where the incident happened, but heard a distinct smack. Followed by a woman's out cry. This nurse then got a call on the walkie [walkie-talkie] from the aide (nursing assistant, NA)." The [NA] stated (in her words) "On 2 a.m. rounds, I went to check resident in room 45-1 (room 45, bed 1) and woke up resident in 45-2 [R47] in the process. I told [R47] the time and said she should lay back down and try and get some sleep until coffee time." [R47] said "No, I want to sit up I'm waiting." NA said "No lets lay down" and NA went to pick up [R47's] feet to bring them in bed and [R47] swung and hit me in the head, fairly hard. I [NA] yelled out "ow" and NA said "why did you hit me, [R47] said, 'I didn't, you hit me you liar' then [NA] walked out and	F 226	On 8/19/15 Social Service Incident Reporting Form (Attachment E) was revised to provide documentation space that clearly identifies the initial evaluators thoughts in regards to: 1) Reason for submission 2) Rationale for NOT submitting report beyond the facility 3) Action taken to Protect The Resident The revision also provides the review team a means to clearly document their evaluation of the incident and any ACTION that they feel needs to be taken on but not limited on the following items: (Attachment F) 1)Timeliness of the report 2) Was Protection of the resident appropriate 3) Reportability decisions were appropriate The vulnerable adult reporting process/guides located at each nurses' station will be updated by 8/25/15. Responsible Person: LSW 8/19/15: 4- separate staff meeting were scheduled for 8/25/15 where the Administrator, DON and LSW will jointly provide nursing staff with training regarding the changes that have been put into place to assist staff in identifying potential abuse and neglect, protecting the resident, discerning reportable injuries of unknown origin and reporting requirements. This staff mtg will also cover the revisions to policies and available tools. All Nurses and NA-R staff will	

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F 226	Continued From page 26 walkie the nurse...." This nurse [LPN-D] asked the res. why she hit the aide. Res. [R47] stated that the aide hit her." The nursing note did not identify the nursing assistant by name. A facility email, written by the SW, dated 1/28/2015, indicated the SW had been verbally informed by LPN-D of R47 being in a conflict with a nursing assistant. The email indicated there was a progress note of the incident, but no further "incident report form." The email indicated the SW further reviewed the progress notes, and because the notes indicated "the resident allegedly struck a NAR [nursing assistant] and also that the resident claimed at the time that the NAR struck her, the incident DOES need to be reported" to the state agency. An Incident Report submitted to the state agency on 1/28/15, indicated: "An incident was verbally reported to this SW in the late afternoon 1/27/15..." and further that R47 had a conflict "this past weekend" with a nursing assistant. Following a review of the related progress notes by the "Stand Up Team" and "Behavior Management Team", it was originally determined incident was due to [R47's] "dementia symptoms..." The report referred to a nursing progress note which indicated that [R47] "claimed at the time that the NAR struck her," thus requiring a report to the state agency, and "an internal investigation done accordingly as per policy." The alleged perpetrator (AP) was unidentified. A review of the SSIRF, the internal email, and the initial report submitted to the state agency indicated an incident occurred sometime during the night shift/early morning hours of 1/25/14.	F 226	be strongly encouraged to attend, an attendance record will be kept and those staff unable to attend will be required to review materials presented and minutes of the meeting. A signature of completion will be required at the time of the review but no later than 9/1/15. Persons responsible: Administrator, DON and LSW 9/20/15: Protection of the Residents After review of all final evidence in the 2567 report NAR-C will be terminated 8/21/15. (NAR-C has been off since 8/10/15, earliest available meeting date for NAR-C prior to next scheduled shift 8/21/15. (Attachment G) MONITORING 1. Audit (Attachment H) of each Social Service Incident Report Form will be reviewed for: timeliness of reporting, appropriateness of report, and actions taken to protect residents The audit will begin with any incident occurring after 8/21/15 and will include every incident reported for the next 3 months (ending 11/21/15) Responsible person: DON and LSW 2. Audit (Attachment I) of each Investigation Report will be completed to:Assure thoroughness of investigations. The audit will begin with any incident occurring after 8/21/15 and will include every incident reported for the next 3 months (ending 11/21/15) Person(s) responsible: DON and LSW Both audit reports will be reported to	

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F 226	Continued From page 27 The report also indicated the incident was first reported, and made known to the SW on late afternoon of 1/27/2014, (two days after the incident) and reported to the state agency on 1/28/2015 (three days after the incident allegedly occurred). There was no indication this incident was reported immediately to the administrator and state agency. Additionally, the investigation of this incident: lacked timely interviewing of NA-C, and other involved staff, and potentially affected residents; did not provide evidence R47 was thoroughly investigated for injuries; and lacked evidence of action to protect residents during the investigation. A final Investigative Report was submitted to the state agency on 2/2/15. The report indicated the SW met with R47 "on the a.m. of 1/28/15 and 1/30/15," and "Resident unable to recall any incidents of concern with any aides the previous weekend." The SW was unable to speak with NA-C, (identified as the nursing assistant involved) until 2/2/15 (7 days after the SW learned of the incident) "in part due to her work schedule not coinciding with the SW." SW spoke with NA-C by phone on 2/2/15, at 10:45 p.m. NA-C "acknowledged the incident happened as described" by LPN-D's note, and further, "[NA-C] saying she had not struck resident in any way, but had merely tried to lift [R47's] legs to help her lay back down..." The report indicated "There is no apparent evidence of NAR striking resident." The investigative report indicated the alleged perpetrator was NA-C. This report also included that NA-C had been implicated in a previous submitted report. During an interview 7/23/15, at 5:10 p.m., the SW	F 226	the Quality Assurance Committee. (QA meets quarterly; Oct., Jan., April and July). Reference Checks: F225 Corrected 8/19/15 Affects Residents R47,R12,R22 R39, R11, R66, R44, R8 and the Potential to affect all Residents 1. 8/18/15 The VA policy was updated (Attachment C) indicating that HR would attempt to obtain information from previous employers and /or current employers during the pre-employment screening process including dates of employment, position held, and feedback on workplace performance 2. 8/18/19 A new Reference Check Form was developed (Attachment J) which identifies documented reference checks with dates of employment, position held and feedback on workplace performance. 3. 8/18/15 The VP of HR provided Training to the HR recruiter on the revised VA Policy, and the new Reference Check Form. The Reference Check Form was implemented on 8/19/15 and will be used on all new hires going forward Monitoring: (attachment K) Responsible Party: VP of HR 4. Biweekly audits will be completed by the VP of HR or designee for for all new hires. The audit will include verification that the Reference Check form was	

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F 226	Continued From page 28 stated in the investigation, R47 was unable to recall if the incident had happened, and that R47 had dementia. The SW said NA-C was not suspended during her investigation because it could not be proven that NA-C abused R47, and NA-C continued to be on the work schedule. The SW said NA-C was counseled on how to provide cares for R47, and was asked for ideas from NA-C on how to keep R47 safe. Review of the facility's MLHS-LTC NA/R Schedule from January 26, 2014 to February 8, 2015, indicated NA-C worked on the night shift on 1/28/15 and 1/29/15, while the investigation of this incident was in progress. R47 had another facility Social Service Incident Referral Form (SSIRF), signed by RN-C indicated R47 was involved in an incident on "3/2/15 early a.m., of possible abuse or resident aggression." The SSIRF indicated: RN-C noted PCC notes (electronic progress notes) by LPN-B questioning verbal statements and other behaviors by resident [R47]; possible indication of maltreatment but just a likely symptoms of resident's dementia." The SSIRF further indicated the incident was discussed with Investigative Team on 3/3/15 at 8:30 a.m., and reported submitted to the state agency on 3/3/2015 at 12:30 p.m. The report also indicated NA-C was a person with credible knowledge of the situation. An initial Incident Report was submitted to the state agency on 3/3/15 regarding possible maltreatment of R47 on 3/2/15. The report referenced "two progress notes from NOC (night) shift early that a.m. of 3/2 that suggests either	F 226	completed for all new hires prior to the first day of employment. Audit reports will be reported to the Quality Assurance Committee. (QA meets quarterly; Oct., Jan., April and July).	

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some behavioral concerns/dementia symptoms by resident [R47] at work or possible maltreatment of resident by staff." The report indicated uncertainty by staff on whether this was maltreatment, and "SW decided to go ahead and submit the allegation to [state agency]...."

A nursing progress note, dated 3/2/215 at 4:03 a.m., written by LPN-B, indicated [R47] was "kicking at staff" and [R47] told staff "she was going to report 'her' to the nurse.." The note also indicated R47 told staff "you go around hitting everyone I heard.." On 3/2/15 at 6:03 a.m., a second progress noted indicated staff went to wipe dry blood off [R47's] lip, and [R47] hit staff. The note continued, that after R47 hit staff, R47 stated "I am going to report you for hitting me."

Facility documentation did not indicate any action was taken to protect R47 and other residents during this investigation of potential abuse. Documentation of the investigation of this incident did not include determination the cause of R47's bloody lip, and there was no evidence of interview with the nursing assistant who provided cares for R47. The SSRIF also indicated there was no immediate reporting of this incident to the state agency or administrator.

A final, Investigative Report was submitted to the state agency on 3/06/15 regarding the incident. The report indicated on 3/2/15 the "resident was interviewed by RN Care Coordinator (RN- A) and this SW. Resident denied remembering anything happening this past weekend during the daytime or the nighttime that upset her in any way.....She denied that anyone hits her or has been mean to her or that she has hit anyone else." The report also indicated "SW communicated with [LPN-B]

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about progress notes from 3/2/15 during night shift, "indicating the NAR was situating resident in the EZ lift (mechanical lift) to help her to the bathroom per resident's request and the NAR noticed resident's lip had been bleeding apparently cracked from being chapped with dry, winter air. [NA-C] told [R47] she was going wipe the dried blood off, but R47 struck out at NA, causing NA's glasses to dismount from her face." The report indicated NA-C re-approached later and assisted [R47] without incident. Later the same night, the NA was doing rounds and attempted to lift R47's feet back in bed, and resident kicked at NA-C. The report then referenced the allegations made by R47, that she was slapped. The report did not confirm a perpetrator in this incident. The report indicated R47's care plan was reviewed, and suggestions were made on how to approach R47 during cares. The report also indicated LPN-B was coached by the SW and DON on more thorough progress note charting, and further, that staff have been reminded to submit timely incident reports. The report included: "Something is just not resting well with this, and although there is no maltreatment of residents 'substantiated' in this particular incident, SW will continue to keep eyes and ears open for patterns and/or trends in conduct, etc."

Review of the facility's MLHS-LTC NA/R Schedule from February 23, 2015 to March 8, 2015, indicated NA-C was assigned to work 3/2/15 (the night of the alleged incident) and also worked on 3/3/15.

During interview 7/23/15, at 5:30 p.m. the SW stated, in review of this incident, she had "concerns with NA-C" but again could not prove

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she had really done anything wrong. The facility felt they could not substantiate the allegations against NA-C, and therefore did not warrant a "suspension or discipline" during the investigation. There was no indication that a thorough investigation was completed for R47.

R12's quarterly MDS dated 4/27/15 indicated she was moderately, cognitively intact and needed extensive assist with dressing, bathing and grooming. R12's care plan dated 1/31/15, indicated she had potential for abuse from others related to cognitive impairment and limited mobility.

A facility Social Service Incident Referral Form (SSIRF), signed by the SW 2/18/15 at 4:15 p.m., indicated there was an incident on "2/18/2015 early A.M.", which alleged "Abuse." The incident was described as: "[NA)-I] asked SW to meet w/ Res re some issues. 9:30 a.m. Res told SW 'I want to go home, they're mean to me here.' 'The lady with the ponytail hurt me when she clean me up yesterday', and 'The other lady slapped me when she tried to make me drink white stuff.' At 4p.m. resident [R12] was still claiming similar concerns." The SSIRF also indicated the following: an internal email report was completed on 2/18/15; that the report of alleged abuse was received by the SW in person, no date or time listed; the incident was discussed with "Investigative Team" on 2/18/15 at 0833; and that the state agency initial report was submitted on 2/18/15 (no time indicated).

An initial Incident Report submitted to the state agency on 2/18/15, indicated on 2/18/15, R12

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was "slapped on her cheek by a staff person early this morning while staff person was trying to get her to take some medicine." The report indicated R12 had no apparent injuries, and "has been consistent with this claim throughout the day..." The report also indicated "a full internal investigation is warranted." The "alleged perpetrator" on the report form was listed as "unknown."

A review of the SSIRF, and the initial report to the State Agency indicated, that although this incident occurred in the early morning of 2/18/15, and possibly earlier, no action was taken by the facility or staff until it was discussed later that morning on 2/18/15. There was no indication the incident was immediately reported to state agency and administrator. Further, the investigation documentation of this incident did not indicate if R12 was slapped; and there was no follow up to have R12 positively identify the nursing assistant, (possibly NA-C) who provided her cares that day. Although NA-C was instructed not to enter R12's room without a colleague present, the documentation offered no indication protections were put in place for other residents who were assisted by NA-C during the investigation of this incident, regardless of its outcome.

A final Investigative Report was submitted to the state agency on 2/23/15. The final report indicated the "Initial Reports submitted to [state agency] ...at 4 p.m.," on 2/18/15, and also a call was made to local law enforcement. The report indicated R12 had made numerous allegations, but the only allegation that could be "tracked, was the one about someone slapping her during the administration of Milk of Magnesia (MOM) that

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morning (the white stuff)." The report indicated SW and DON proceeded to seek more information about who would have administered the MOM that morning. The report identified, according to the schedule, LPN-B and NA-C were the persons on duty. Further, the report indicated, "DON and SW met with [NA-C], who freely admitted having given MOM upon the direction of [LPN-B]." The report continued, "[NA-C] said resident didn't want the MOM, and resident took the cup and threw the MOM all over." and "[NA-C] tried to clean it up off the bedding, resident's clothing and her face, using wet wipes." The report indicated "[NA-C] denied slapping resident in any way, but acknowledged wiping R12's face off with the wet ones." The report indicated "It is possible this was perceived by [R12] as a slap." Next, the report indicated, the SW asked NA-C to go to resident's room to see if resident could or would identify her as the lady who slapped her, and NA-C agreed to do so. "[R12] was sleeping soundly, however, so decided not awaken her." The report indicated "NA-C's willingness to go, however, leads SW to believe she [NA-C] is being truthful about not slapping resident." The report indicated the DON spoke to LPN-B by phone on 2/23/15 at 3:20 p.m. LPN-C admitted asking NA-C to give MOM to R12 due to LPN-C being occupied elsewhere LPN-C also acknowledged that NA-C did report (R12's) claim of being slapped by a "blonde lady." The report then indicated staff have been alerted to having "two persons present" during cares with this resident and NA-C was instructed not to enter room without a colleague present.

During interview on 7/23/15, at 5:20 p.m. the SW stated she did not suspend NA-C since "they could not prove [NA-C] slapped [R12.]" The SW

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acknowledged NA-C had been involved in multiple incidents, and had "suspicions" with [NA-C], but did not feel "there was a reason to suspend" or provide disciplinary action to her during this investigation.

Review of the facility's MLHS-LTC NA/R Schedule from February 9, 2015 to February 22, 2015, indicated NA-C worked on 2/17/15 through 2/22/2015, that is on the date of the alleged incident, and during the subsequent investigation. There was no indication a thorough investigation was completed for R12.

R22's admission MDS dated 4/24/15, indicated she had depression and a cerebral vascular accident (CVA), and was moderately cognitively impaired and needed limited assist with transfers and extensive assist with toileting. R22's care plan dated 5/3/15, indicated she needed assist with toileting and transfers, had history of depression and sadness/isolating self. R22's care plan further indicated she had potential for abuse from others related to her general weakness, aches and pains. The care plan goal indicated "resident will remain safe and have needs met in a safe environment."

During observation on 7/20/15 at 5:54 p.m., R22 lifted her pant leg and displayed a bruise on her right shin measuring approximately 8 cm (centimeters) x 2 cm. R22's bruise was noted to be black, fading to dark purple in color, with no apparent swelling. In an interview 7/20/15, at 5:54 p.m. R22 stated that she had been treated "roughly by the staff" and there is "a staff member who works the night shift that is rough with her."

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R22 went on to state this staff member had "grabbed her arm when transferring" which caused a large bruise and also stated she had also hit her leg into the metal bar along the bottom of her bed.

The facility submitted an Incident Report to the state agency on 6/27/15 regarding an incident of alleged mistreatment and physical abuse of R22. The report also identified a bruise on R22 top right hand, measuring 5.5 cm x 5 cm, circular in shape; and a second bruise on R22's lower right shin 2.5 cm x 2.5 cm, circular in shape. The report was submitted by RN-D, and indicated that the initial reporter, NA-C, was also the alleged perpetrator in this incident. The report indicated, nursing assistant (NA)-C reported at 5:15 a.m., she had toileted R22, after being toileted, R22 told [NA-C] she was not coming back tonight,and that "some girl hurt her." NA-C asked who, and she [R22] stated she doesn't know who. The report then indicated that registered nurse (RN)-A, followed up with R22 in the morning and asked her to tell her what happened: "Resident reported she is not staying her again tonight and is not going to be treated like this anymore." R22 explained that staff was mad at her during the night for getting up to use the bathroom so many times, and that a "girl grabbed me and threw me into bed." R22 pointed out her hand hurt, and said "this is where she grabbed me," noted a bruise on top of right hand measures 5.5 cm (centimeters) x 5 cm circular is shape. R22 also reported when she threw me into bed, "I hit my leg on something metal" a bruise noted on right outer lower shin measures 2.5 cm x 2.5 cm circular in shape. R22 could not recall who the girl was, nor her name. R22 thought it was around 0400. The report further indicated NA-C

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was the nursing assistant working on that wing during the night, and LPN-A was the nurse in charge. No other injuries noted, resident was reassured she will remain safe here, NA-C will be removed from working with resident at this time.

An additional Incident Report was submitted to the state agency on 7/1/15, which identified an injury of unknown source on R22's right forearm "8 x 5 cm, reddish purple in color and oval in shape." The date of incident occurrence was unknown. The report indicated R22 said "It happened a few days ago."

An Investigative Report was submitted to the state agency on 07/02/15, which combined two submitted incident reports dated 6/27/15 and 7/1/15. The report indicated the director of nursing (DON) and social worker (SW) "have tried to investigate this issue thoroughly and have been unable to substantiate who the alleged perpetrator [AP] is for certain, but have reached a conclusion there is reasonable suspicion a crime may have occurred in the form of assault, and are hence submitting a report also to law enforcement, in accordance with Elder Justice Act." Further the report indicated, "The details of our internal investigation to the limits of our ability are being submitted to OHFC and the state agency." The Investigative Report further indicated on 7/1/15, the DON and SW met with the AP, (NA-C) who stated R22 had requested to use the toilet 6-8 times that night (6/27/15). The report then indicated [SW and DON] "discussed with the AP the number of previous incidences involving this NAR, which can raise red flags re her credibility, and she became somewhat defensive, face reddening and voice tightening, saying 'it's because I report things and others

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don't, so I end up getting in trouble.' " The report further listed, that during an interview 7/2/15 the DON and SW meet with NA-D, who stated she "reported having heard from resident (R22) on 6/30, that [R22] is afraid of the girl with the blonde hair and bangs, that she is not very nice, etc. The blond hair with the bangs fits description of NA-C. The report further included that NA-C had been "implicated in previous reports 75814, 78740, and 79433 with possible "power struggles" with residents, as she tries to perform cares; received coaching in these incidents. NA-C was also involved in report 79866 but was not specifically named as AP."

Although R22 had described NA-C as the staff member who had hurt her and NA-C was caring for her and received multiple large bruises, the incident documentation indicated no action taken to protect residents during investigation of these incidents. Also, there was no indication that a thorough investigation was completed that included other interviews with staff and residents.

During interview on 7/23/15, at 4:50 p.m. the DON stated she "has concerns that NA-C might be doing the accusations," but stated she "was not certain." The DON said, "staff monitor [NA-C] during the night shift," and also "we have nurses on that do that." The DON stated the nurses were to report to her if they notice anything and have concerns.

In an interview on 7/23/15, at 5:03 p.m., the SW stated she "did not talk with other residents or staff regarding abuse allegations by [R22]." The DON stated, "I don't generally do that, it's not a witch hunt." The DON said, "Just because their name keeps coming up does not make them

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guilty." The DON also said there were issues around "data privacy and confidentiality." SW further stated, when something regarding abuse allegations come up over the weekend, the nurse on duty initiates the OHFC reporting. The SW said the nurse would talk to the resident, and address any immediate concerns. Regarding NA-C, the SW stated, "At times there have been several residents she is not allowed to care for, but that does change if, during the investigation the allegation is not substantiated." The SW further stated, in regard to NA-C, after the first allegation of abuse, " a lot of coaching was done." The SW also said the coaching for NA-C was "not intensive, and there was no improvement plan initiated and no documentation of education or mentoring done."

During an interview on 7/23/15 at 5:10 p.m., the administrator said, "We have three young people working on nights, we can't suspend; there is not enough staff." The administrator further stated, " I feel the DON and SW did the right thing."

During an interview on 07/23/15, at 5:14 p.m., the DON stated NA-C was not suspended per the facility policy following the allegation made by R22 . She stated, "If I had suspended one, I would have had to suspend all three staff, then who would take care of the residents?"

During an interview on 07/24/15 5:14 a.m., NA-E stated, " I don't work a lot of overnights unless I am mandated, but I do hear a few things." NA-E stated, "I have heard about people being super wet and I have heard that some of the girls are a little rough, but I can't tell you who." She further stated, one of the resident mentioned about a girl being rough and leaving bruises. NA-E described

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the staff member as they were described by the resident and stated the resident said " the girl threw me into the chair because I had to go to the bathroom again." NA-E stated she does not see the nurse a lot on nights.

During interview on 7/24/15, at 5:25 a.m. LPN-H stated she works part time on the night shift. LPN-H stated she has heard from other NAs that NA-C is rough with the residents but had not witnessed it directly. LPN-H stated she is not aware that she is to monitor any staff during the night shift when she works. She further indicated she had heard R12 had reported that NA-C had slapped her and also that NA-C no longer works on the North wing and thought the reason was because of the cat not because she can not take care of any certain residents. She then stated the aides on the night shift don't work together they prefer to work on each unit alone.

INJURIES OF UNKNOWN ORIGIN

The facility Vulnerable Adult Policy, revised 7/15, defined Injury of Unknown Origin as "...source of the injury was not observed and injury as suspicious." The policy did not expound on this definition to include criteria from the CMS interpretive guidance.

R39's annual MDS, dated 3/9/15, indicated she was moderately, cognitively impaired. The CP, dated 3/30/15, indicated R39 required extensive assist with all activities of daily living (ADLs), used a mechanical stand for transfers, and was identified at risk for abuse, because of dementia.

A review of SSIRF dated 10/7/14, indicated R39

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had a large, dark purple bruise on the right upper portion of her buttock, and it was an "unknown" injury, and R39 was "unaware" of how the bruising occurred. The SSIRF also indicated R39 "a few days ago had been lowered to floor due to not standing when transferring & then lifted with Hoyer (a mechanical lift) Possible cause." The SSRIF further indicated R39 used a medication that could explain bruising, and also that R39's chart contained "falls or other recent incidents that could likely have produced the injury." The SSIRF indicated R39's injury was "minor" and not reported to the state agency. No further investigation was completed for this incident even though there was no indication R39 had struck any objects or the floor as she was lowered to the ground.

During an interview on 7/24/15, at 12:54 p.m., the DON stated, when R39 had been lowered to the floor "it would be hard to know if injury occurred during that event." The DON said R39 bruised easily due to use of anticoagulant medication, so therefore the injury was "not considered reportable."

Although R39 was moderately impaired and unable to recall how the bruise occurred, there was no evidence that a more in-depth investigation was completed to determine the actual cause, nor was R39's injury of unknown origin reported to the state agency.

R11's quarterly MDS, dated 4/15/15, indicated she was moderately, cognitively impaired. The CP, dated 6/3/15, indicated R11 required extensive to total assist for all ADLs, and was at

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risk for abuse related to depression.

A review of SSIRF dated 10/21/15, indicated R39 had a bruise to the top of her right hand, dark purple in color, and measured 8 cm x 8 cm. The SSIRF indicated R11 was unable to state how the injury occurred, but R11 used anticoagulant medication, and R11's bruise was described as "minor." The facility administrator was notified but no report was made to the state agency.

A second SSIRF, dated 11/4/14, indicated R11 had bruising noted to her left temple and above her left eyebrow. The SSIRF indicated R11 was unable to state the cause of the injury. The facility administrator was notified, but the injury was not reported to the state agency.

A third SSIRF dated 12/18/14, indicated R11 had a bruise of unknown origin to her left inner knee, dark purple in color, and measuring 1 x 1 3/4 inches. The SSIRF indicated the injury was "unknown", that R11 was unable to report the cause of the injury, used anticoagulants; and also indicated the injury was considered to be "minor." The facility administrator was notified, but the injury was not reported to the state agency.

During an interview about the three injuries of unknown origin on 7/24/15, at 12:54 p.m., the SW stated, R11 "had more bruising than anyone I have ever known." The SW said the bruise on R11's hand "may have been caused by recent trimming of [R11's] nails," indicating R11 caused the bruise herself. Regarding the bruise noted to R11's temple and forehead, the SW stated that nursing felt the bruising "was due to placement of [R11's] nebulizer mask," however, the SW stated, she interviewed R11 who reported that

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she slipped and fell on her way back from supper. SW further stated R11 did not ambulate, used a Hoyer lift [a mechanical lift] for transferring, and there were no records of any falls. SW added the bruising was "likely due to placement of [R11's] nebulizer mask." No further investigation was completed for this injury.

During an interview on 7/24/15, at 12:54 p.m., the DON stated R11 "could reliably answer" when the reporting nurse asked if bruising was related to abuse, therefore, the DON felt the injury was not reportable.

Although R11 was identified to be moderately cognitively impaired, and had multiple bruises at different locations, there was no indepth investigation completed to determine the actual causes of R11's bruises. The facility administrator was notified of the injuries but none of these incidents were submitted to the state agency.

R66's quarterly MDS, dated 1/7/15, indicated she was moderately, cognitively impaired. The CP, dated 2/9/15, indicated R66 required extensive assist of two staff, with use of a mechanical lift, for transfers. The CP also indicated R66 was at risk for delirium and potential abuse, related to depression.

A review of SSIRF dated 2/3/15, indicated during a review of R66's nursing progress note dated 1/26/2015, there was "presence of unknown bruises" on [R66] both arms, the size was identified as bruising "from hands to shoulder." The SSIRF also indicated R66 now wore sleeve/arm protectors. The SSIRF indicated this

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was an "unknown injury", that R66 was unable to state the cause, and that the injury was assessed to be "minor." The injury was reported to the facility administrator, but was not not reported to the state agency.

During an interview on 7/24/15, at 12:54 p.m., the SW stated, the bruises were noted while the DON was reviewing R66's progress notes. The SW said she "spoke with nursing" and determined the bruising was assessed "to be a minor injury, and therefore not reportable to the state agency."During an interview on 7/24/15, at 12:54 p.m., the DON said R66 used a Hoyer lift (mechanical lift), and R66 did not always cooperate in lift, occasionally "flailing her arms." The DON further stated R66 was confused, and that it would be "hard to say if R66 would have been able to to talk about how the bruising occurred after any time had passed."

Although R66 had bilateral bruising from her hands to her shoulders, the injury was unwitnessed and the resident was unable to identify what happened. The facility had not immediately reported the incident to the state agency nor was a thorough investigation completed to determine if R66 was "flailing her arms" while using the mechanical lift.

R44's annual MDS, dated 6/9/15, indicated she was severely cognitively impaired. The CP, dated 7/10/15, indicated R44 required extensive assist with ADLs, and was at risk for abuse, related to short term memory loss and impaired decision-making skills.

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A review of SSIRF dated 6/15/15, indicated R44 had a purple bruise on her posterior (back side) forearm, measuring 6.3 cm x 7 cm, that was found during her bath. The SSIRF indicated this was an "unknown" injury, and R66 could not state the cause of injury. The injury was determined to be "minor". The facility administrator was notified, but the injury was not reported to the state agency.

During an interview on 7/24/15, at 12:54 p.m., the SW stated, "The injury was determined by nursing staff to be 'minor' and did not meet any suspicious criteria. The SW said she "did not see a need to report" to the state agency.

In an interview on 7/24/15, at 12:54 p.m., the DON stated, "[R44] would have been able to tell you if something happened, she could make her needs known."

Even though R44 was assessed to be severely cognitively impaired, had an injury of "unknown" origin, on the posterior of her arm. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency.

R8's quarterly minimum data set (MDS) identified her to be severely cognitively impaired and requiring assist of two staff for activities of daily living. CP dated 5/15/15 indicated R8 required extensive assist for activities of daily living and was at risk for abuse related to diagnosis of dementia.

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F 226	Continued From page 45 A review of SSIRF dated 8/18/14, indicated R8 had a bruise measuring 8.5cm in length between her thumb and forefinger from the base of her thumb to her wrist. The reporting nurse did the initial evaluation and determined the bruising resulted from R8 wringing her hands, and the wringing of her hands was witnessed by staff. During an interview on 7/24/15, at 12:54 p.m., SW stated, the injury was not reportable due to staff witness of the potential cause. No further investigation of the injury was completed. The facility administrator was notified of the injury but a report was not made to the state agency. A Social Services Incident Referral form was requested for this injury but was not received. Although R8 had severe cognitive impairment, and had a bruise 8.5cm between her thumb and forefinger from the base of her thumb to her wrist. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency. During an interview on 7/24/15, at 12:54 p.m., SW stated, when making a determination of whether or not to report an injury to the state agency, she "refers to statutes, and uses a decision tree." The SW also stated that she looks at whether a resident is able to explain the injury, or if someone else saw it, and if there was a history of other recent falls and/or injuries. The SW further stated, "If the nurses indicated minor injury or injury not suspicious in nature or location, it does not need to be reported."	F 226		

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During an interview on 7/24/15, at 12:54 p.m., the DON said, minor injuries are not reportable to the state agency. She further stated, there was "no criteria or policy" the facility has to identify and determine whether an injury was "minor" versus "major." The DON also stated she "would use the nurses judgement" when determining if an injury was minor or major, and that the RN in charge "followed up on the injuries." However, she stated there was no charting on the clinical record that would show evidence that follow-up had been completed.

REFERENCE CHECKS

The facility's Abuse Prevention Policy, revised 7/15, indicated as its purpose "...to protect adults who are vulnerable to abuse..." Further, the policy included: "To assure the facility was doing everything within its control to prevent the occurrence of abuse or neglect...the facility would attempt to obtain information from previous employers and or/current employers."

NA-A's personnel record identified they were hired on 7/13/15. The personnel record lacked evidence reference checks were completed prior to employment at the facility.

NA-B's personnel record identified they were hired on 6/30/15. The personnel record lacked evidence reference checks were completed prior to employment at the facility.

Dietary Aide (DA)-A's personnel record identified they were hired on 6/23/15. The personnel record lacked evidence reference checks were

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F 226	Continued From page 47 completed prior to employment at the facility. Registered nurse (RN)-B's personnel record identified they were hired on 5/11/15. The personnel record lacked evidence reference checks were completed prior to employment at the facility. On 7/23/15, at 8:45 a.m. human resources (HR) staff stated four of the five newly hired employees did not have documentation of reference checks. HR stated there was "not a process" to document that reference checks had been completed. They facility used the application references "to inquire about the position held, date of hire, eligibility for rehire and any feedback."	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified rising and morning routines for 2 of 8 residents (R50 and R12),who required extensive staff assistance to complete activities of daily living (ADL's). R50's diagnoses, as identified on the care plan (CP), reviewed 6/6/2015, included hemiplegia, dementia, and aphasia. The quarterly Minimum Data Set (MDS), dated 5/27/2015, indicated R50	F 241	F241 Affects R50 &R12. Potential to affect all residents 1. 8/11/15:Dignity & respect & it's relationship to cares was discussed at the nsg staff meeting 8/11/15. 2. 8/14/15: NAR night duty assignment sheet was revised (Attachment L) 3.8/14/15: an email to all NARs regarding dignity & respect and AM cares was sent by the DON & included.	8/14/15

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F 241	Continued From page 48 had severely impaired cognition, required extensive, physical assistance for ADL's, including two-person assist with bed mobility, transfers, toileting, dressing and personal hygiene. During observation on 7/22/2015 at 7:11 a.m., R50 was lying on her back, in her bed, with her left hand positioned on top of her chest. R50's blanket was at the foot of the bed, pulled onto the resident, exposing R50's left leg, and one could see she already had pants on as she lied in bed. R50 remained in bed until 8:41, when NA-F and NA-G assisted her with morning cares. R50 was already dressed, with pants, socks and shirt, when NA-F removed R50's covers and checked for incontinence, NA-F and NA-G assisted R50 into her wheel chair with use of a mechanical lift. NA-F then brushed her hair, and NA-G assisted in placing R50's hand splint and arm into the wheel chair armrest and R50 was up for the day. During an interview on 7/22/2015 at 8:38 a.m., NA-G said R50 was already dressed this morning, and we "just needed to get up, out of bed." NA-G said R50 needed "total assistance" dressing, and R50 was not able to verbalize her needs to staff. In an interview on 7/22/2015 at 9:18 a.m., NA-F acknowledged R50 was dressed this morning when she assisted R50 to get up for the day. NA-F did not know who worked with R50, but said "someone on nights [the night shift] got her dressed," and that was typical for R50's routine. NA-F also said R50 would not be dressed early on Tuesdays, "because she gets a bath on that day."	F 241	"No resident should be gotten up on the noc shift for the convenience of staff. Only Residents who are awake & choose to get up or if they are restless & attempting to get out of bed and or it is written in their care plan that they get up at a specific time". Monitoring 8/24/15- 9/28/15 An audit will be performed every day x1 week, then every week x4 weeks to ensure dignity & respect of all residents with their AM cares. The day nurse/TMA who arrives @0600 will round on their scheduled wing. They will observe and document the residents who are up and or dressed and back in bed. The report will be given to the RN Care Coordinator for review if Dignity & Respect was provided. The Care Coordinator will forward the review form to the DON after their review. (Attachment M) Responsibility: Nurses/TMA, Care Coordinators & DON Audit reports will be reported to the Quality Assurance Committee. (QA meets quarterly; Oct., Jan., April and July).	

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During an interview on 7/24/2015 at 6:00 a.m., NA-H stated she works on the overnight shift, and routinely got R50 "cleaned up and dressed," but not removed from bed, "the day shift would do that." NA-H stated she does not get R50 dressed on her scheduled bath days. She has a list of residents whom she helped get cleaned and dressed, prior to the end of the night shift. NA-H said "I just need to make sure they are dressed and ready to go. I get them dressed and then put them back to bed; it helps out the morning shift." NA-H said if there was a resident that did not want to get up, she was instructed "to get someone else up." NA-H did add that some of the residents she assisted "liked to get up early," and there were some who simply "were up all night anyway."

During an interview on 7/24/2015 at 1:06 p.m., family member (FM)-A said he was unaware staff were getting R50 dressed, then having her stay in bed. FM-A said that depending on the night, R50 was often awake late, or was "up at 3:00 a.m. and restless, and they [staff] will get her up." FM-A than stated, "I would think if [R50] got dressed, she'd be getting out, and up to breakfast for the day."

In an interview on 7/24/2015 at 1:17 p.m., the director of nursing (DON) stated the night shift try "to help the day shift staff." The DON said "If someone was trying to get up, then get them up, and keep [the resident] from getting out of bed and possibly fall." In the same interview, the social worker (SW) said getting a resident up during the night was "not just a decision for the aide. We should look into this some more."

R12's quarterly minimum data set (MDS), dated

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5/18/15, indicated she was severely, cognitively impaired and required extensive assist for transfers, dressing and grooming. The care plan (CP), dated 8/28/13, directed staff to give R12 opportunities to make daily preferences choices, including clothing, bed time and bathing. The CP also indicated R12 had an alteration in sleep, related to insomnia, with a goal of at least six hours of sleep at night. The CP did not address a morning routine preference of when R12 wanted to get up.

During observation on 7/22/15 at 7:00 a.m., R12 was noted fully dressed and seated in her wheel chair. R12 was positioned in front of the television in the common area on the east wing, asleep in her wheelchair. R12 repeatedly made jerking movements as she dozed. R12 remained in chair until 8:15 a.m., (75 minutes) when staff approached, and awakened her. The staff asked R12 if if she wanted to go back to bed, or eat breakfast. R12 replied "I don't care."

During an interview on 7/24/15, at 5:59 a.m., NA-E stated she was instructed to get four residents up, washed and dressed when working the over night shift. NA-E stated if a resident had shower, there was another one assigned to get up in their place. NA-E stated she will usually "get the residents up, washed, dressed and put them back to bed."

During an interview on 7/24/15 12:24 p.m., licensed practical nurse (LPN)-C stated, " usually the over night shift is getting up the early risers, she stated they are not getting up anyone that would normally sleep in. LPN-C further stated, "Some of the Hoyers [residents who require use

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of a mechanical lift to transfer] get washed, dressed and put back in bed, I don't have any idea why they would do that."

During an interview on 7/24/15, at 1:16 p.m., the director of nursing (DON) stated, there are many people getting up and dressed and put back to bed on the night shift. She stated, The nurses and care coordinators schedule them to help the day shift. The DON further stated, "the people on this list are usually up or crawling out of bed," we like the night shift to help day shift "get a jump on the day." She further stated, "I'm sure we are not the only nursing home in the world that does that." The intent is to help day shift out and prevent falls. The DON stated she was not sure if the rationale for waking a resident on night shift to get them washed and dressed is on the care plan or not.

During an interview on 7/24/15, at 2:07 p.m., registered nurse (RN)-C stated, We schedule residents for the night shift to get up, washed and dressed. She stated, We usually look at people who are trying to get up but if there aren't enough people who want to get up, we will pick people who are a "Hoyer lift." The aides will wash and dress them in bed. RN- C stated, "If someone prefers to get up early it is not care planned." She further stated, there is no one currently on the East unit that is care planned to get up early due to fall risk. RN-C stated, The rationale for night shift getting resident's washed and dressed is due to the workload in the morning.

Review of the facility's undated East night group sheet directed night shift to complete morning cares, oral cares, dressing, making bed and cleaning up room for five residents on the unit,

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F 241	Continued From page 52 including R12. A review of the facility policy, Rights and Responsibilities of Patients/Residents, dated 4/15, indicated the facility "must, with courtesy, promote care for [residents] in a manner that maintains and enhances dignity and respect in full recognition of [a resident's] individuality."	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care for timely repositioning and toileting assistance for 1 of 1 residents (R50) with urinary incontinence, and at risk for pressure ulcer development. Findings include: R50's diagnoses, as identified on the care plan (CP), reviewed 6/6/2015, included hemiplegia affecting dominant side, dementia, and aphasia due to cerebrovascular disease. The quarterly Minimum Data Set (MDS), dated 5/27/2015, indicated R50 had severely impaired cognition, and was unable to walk. The MDS also identified R50 required extensive, physical assistance for activities of daily living (ADLs), including two-person assist with bed mobility, transfers,	F 282	F282: Affects R50 with the Potential to Affect All Residents requiring repositioning and toileting. 1. On 7/23/15: an email was sent to all LTC staff, including Activity staff, by the Care Coordinator. indicating the following: "Make sure resident's are being toileted and repositioned @ minimum of every 2 hrs. or more frequently if noted in the care plan. 2. A toileting/reposition/skin worksheet (Attachment N) will be placed in the NAR three ring binder @ each nurses' station. Staff will document each time that they assist the resident with repositioning and or toileting. Monitoring An audit of the toileting/repositioning/skin	8/20/15

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F 282	Continued From page 53 toileting, and personal hygiene. R50's care plan (CP) identified the potential for alteration in skin integrity, and also R50's alteration in elimination/toileting. The CP directed staff to follow the mobility plan of care, and assist R50 "to turn and reposition every 2 hours and PRN" [as needed]. Additionally, the CP directed staff to assist R50 "to check and change every 2 hours and PRN" [as needed]. During continuous observation on 7/23/2015 from 7:55 a.m. to 11:12 a.m. (3 hours and 7 minutes) R50 was observed to be dressed and seated upright in her wheel chair. At 7:55 a.m., R50 was seated in her wheel chair in the living area across from the north unit nursing station and watching a news program on TV. At 8:33 a.m., R50 was wheeled into the dining room and assisted with breakfast, finishing at 9:36 a.m. Following the meal, and still seated in the wheel chair, R50 was moved from the table where food was served to the activity area in the same room. R50 participated in the morning activity, and stayed in the activity area until just after 10:00 a.m., when a staff member wheeled her into the main entryway of the facility. R50 remained there, still seated in her wheel chair, until 10:19 a.m., when a staff member pushed R50 outside of the building, joining other residents to get fresh air. At 10:37 a.m., R50 was returned into the building near the aviary, and was approached by nursing assistant (NA)-F, who after greeting R50, took her vital signs. More than 2 1/2 hours had elapsed since R50 was last toileted or repositioned. R50 remained seated in her wheel chair near the aviary until 11:12 a.m., when NA-F assisted her back to her room. In her room, NA-F and registered nurse (RN)-B, using the mechanical	F 282	worksheet will be completed by nursing 1x/shift for 1 week then weekly x4 weeks (8/26/15-9/30/15) (Attachment O) Responsibility: DON, Care Coordinators, Nursing Staff. Audit reports will be reported to the Quality Assurance Committee. (QA meets quarterly; Oct., Jan., April and July).	

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F 282	Continued From page 54 lift, assisted R50 into her bed. R50 was incontinent of urine, and NA-F provided perineal care. RN-B assessed R50's skin, which was pink in color, free of any unusual warmth or swelling, there were no reddened areas, and her skin was fully intact. RN-B also said R50 was incontinent of urine. R50 was not toileted or repositioned from 7:55 a.m. to 11:12 a.m., a total of 3 hours and 7 minutes. During an interview on 7/23/2015 at 11:16 a.m., nursing assistant (NA)-F stated R50 was last repositioned when she was put in her wheel chair "at about quarter to eight." NA-F then stated R50 was on an "every two hour repo [repositioning] schedule," and that R50 should also be checked for "urinary incontinence." NA-F said R50 "Was definitely ready to be repositioned." In an interview on 7/23/2015 at 4:00 p.m. registered nurse (RN)-A said she "trusted the work group on the floor to get toileting and repositioning completed," but what happened today, "I'll say was a fluke." RN-A also stated, "I'll be honest, [R50] should have been turned." During an interview on 7/27/2015 at 1:19 p.m., the director of nursing (DON) said resident interventions were care planned, and the facility takes "very seriously, residents' needs for timely assistance." A facility policy regarding the implementation of care plans was requested, but none provided.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314		8/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245127	A. BUILDING _____ B. WING _____	07/27/2015

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F 314	Continued From page 55 resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning for 1 of 2 residents (R50) reviewed in the sample identified at risk for development of pressure ulcers. Findings include: R50's diagnoses, as identified on the care plan (CP), reviewed 6/6/2015, included hemiplegia affecting dominant side, dementia, and aphasia due to cerebrovascular disease. The quarterly Minimum Data Set (MDS), dated 5/27/2015, indicated R50 had severely impaired cognition, and was unable to walk. The MDS also identified R50 required extensive, physical assistance for activities of daily living (ADLs), including two-person assist with bed mobility, transfers, toileting, and personal hygiene. A Braden Pressure Sore Risk Assessment, dated 5/26/2015, indicated R50 was at moderate risk for development of pressure sores. A comprehensive skin assessment summary, dated 5/26/2015, identified R50 required extensive to total assist with ADLs, that she was unable to walk, and was on a turn-and-reposition schedule every 2 hours. The care area assessment (CAA)	F 314	F314 affects R50 and has the potential to affect all residents requiring physical assistance with ADL's and are at a risk for developing pressure ulcers. 1. On 7/23/15: an email was sent to all LTC staff, including Activity staff, by the Care Coordinator. indicating the following: "Make sure resident's are being toileted and repositioned @ minimum of every 2 hrs. or more frequently if noted in the care plan. 2. A toileting/reposition/skin worksheet (Attachment N) will be placed in the NAR three ring binder @ each nurses' station. Staff will document each time that they assist the resident with repositioning and or toileting. Monitoring An audit of the toileting/repositioning/skin worksheet will be completed by nursing 1x/shift for 1 week then weekly x4 weeks (8/26/15-9/30/15) (Attachment O) Responsibility: DON, Care Coordinators,	

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F 314	Continued From page 56 for pressure ulcers, dated 2/25/2015, identified additional pressure ulcer risk factors for R50 including immobility, incontinence, cognitive loss and functional limitation in range of motion. R50's CP identified the potential for alteration in skin integrity. The CP directed staff to follow the mobility plan of care, and assist R50 "to turn and reposition every 2 hours and PRN" [as needed]. The nursing assistant care sheet "North" unit, undated, directed for R50: T & R q 2 hrs [turn and reposition every 2 hours]. During continuous observation on 7/23/2015 from 7:55 a.m. to 11:12 a.m. (3 hours and 7 minutes) R50 was observed to be dressed and seated upright in her wheel chair, with her right hand and wrist fitted with a splint device, and her right arm was supported and strapped into the arm rest. At 7:55 a.m., R50 was seated in her wheel chair in the living area across from the north unit nursing station and watching a news program on TV. At 8:33 a.m., R50 was wheeled into the dining room and assisted with breakfast, finishing at 9:36 a.m. Following the meal, and still seated in the wheel chair, R50 was moved from the table where food was served to the activity area in the same room. R50 participated in the morning activity, and stayed in the activity area until just after 10 a.m., when a staff member wheeled her into the main entryway of the facility. R50 remained there, still seated in her wheel chair, until 10:19 a.m., when a staff member pushed R50 outside of the building, joining other residents to get fresh air. At 10:37 a.m., R50 was returned into the building near the aviary, and approached by nursing assistant (NA)-F, who after greeting R50, took her vital signs. More than 2 1/2 hours had elapsed since the initial observation, and still R50	F 314	Nursing Staff. Audit reports will be reported to the Quality Assurance Committee. (QA meets quarterly; Oct., Jan., April and July).	

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F 314	Continued From page 57	F 314		

was not off loaded, or repositioned out of her wheel chair. R50 remained seated in her wheel chair near the aviary until 11:12 a.m., when NA-F assisted her back to her room. In her room, NA-F and registered nurse (RN)-B, using the mechanical lift, assisted R50 into her bed. R50 was incontinent of urine, and NA-F provided cleansing cares for her. In the presence of the surveyor, RN-B inspected and assessed R50's skin. R50's skin was normal pink in color, free of any unusual warmth or swelling, there were no reddened areas, and her skin was fully intact. RN-B also said R50 was incontinent of urine. R50 had not been repositioned from 7:55 a.m. to 11:12 a.m., a total of 3 hours and 7 minutes.

During an interview on 7/23/2015 at 11:16 a.m., nursing assistant (NA)-F stated R50 was last repositioned when she was put in her wheel chair "at about quarter to eight." NA-F then stated R50 was on an "every two hour repo [repositioning] schedule," and R50, "Was definitely ready to be repositioned."

A review of nursing and physician long-term care progress notes from 3/26/2015 to 7/14/2015, indicated R50 did not have, nor was being treated for a current pressure ulcer. During this time, R50 did not develop a pressure ulcer.

In an interview on 7/23/2015 at 4:00 p.m. registered nurse (RN)-A stated she would consider any resident "who had a stroke to be at risk for pressure sores." RN-A also said she would "look at everything" to determine if a resident was at risk to develop a pressure ulcer. RN stated R50 scored "a 13 on the Braden" (a measure for predicting pressure ulcer risk), but that also R50 "had immobility, incontinence, and

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F 314	Continued From page 58 other risk factors" and was "at risk for pressure." RN-A said she trusted the work group on the floor to get toileting and repositioning completed, but what happened today, "I'll say was a fluke." RN-A also stated, "I'll be honest, she should have been turned." During an interview on 7/27/2015 at 1:19 p.m., the director of nursing (DON) said the nurse manager had already taken steps to avoid issues when a resident is on a schedule to be turned and checked for incontinence. The DON said in this instance, "[R50] should not go right from breakfast into other activities, that is too long." The DON said resident interventions were care planned, and the facility takes "very seriously, residents' needs for timely assistance." A facility policy, Treatment and Prevention of Skin Breakdown and Ulcers, reviewed 3/14, indicated "It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity..." and "implement preventive measures..." Further, the policy directed, to "establish and record an individualized turning and repositioning schedule if the resident is immobile."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	F 315		8/20/15

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F 315	Continued From page 59 infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely toileting assistance for 1 or 1 residents (R50) who had urinary incontinence. Findings include: R50's diagnoses, as identified on the care plan (CP), reviewed 6/6/2015, included hemiplegia affecting dominant side, dementia, and aphasia due to cerebrovascular disease. The quarterly Minimum Data Set (MDS), dated 5/27/2015, indicated R50 had severely impaired cognition, and was unable to walk. The MDS also identified R50 required extensive, physical assistance for activities of daily living (ADLs), including two-person assist with bed mobility, transfers, toileting, and personal hygiene. A bowel and bladder assessment, dated 2/25/2015, indicated R50 was incontinent of bowel and bladder, and also was not safe to use a commode or toilet due to poor trunk control. Further, the assessment indicated R50 would "be checked for incontinence q 2hr [every 2 hours] and peri care given after each incontinence episode." The care area assessment (CAA) for urinary incontinence, dated 3/11/2015, indicated R50 had dementia, and past history of cardio-vascular accident (stroke), with right-sided hemiplegia. The CAA also indicated R50 was not a candidate for retraining. R50's CP identified alteration in elimination/toileting, that she was incontinent of	F 315	315: Affects R50 with the Potential to Affect All Residents who have urinary incontinence & require assistance with toileting 1. On 7/23/15: an email was sent to all LTC staff, including Activity staff, by the Care Coordinator. indicating the following: "Make sure resident's are being toileted and repositioned @ minimum of every 2 hrs. or more frequently if noted in the care plan. 2. A toileting/reposition/skin worksheet (Attachment N) will be placed in the NAR three ring binder @ each nurses' station. Staff will document each time that they assist the resident with repositioning and or toileting. Monitoring An audit of the toileting/repositioning/skin worksheet will be completed by nursing 1x/shift for 1 week then weekly x4 weeks (8/26/15-9/30/15) (Attachment O) Responsibility: DON, Care Coordinators, Nursing Staff. Audit reports will be reported to the Quality Assurance Committee. (QA meets quarterly; Oct., Jan., April and July).	

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F 315	Continued From page 60	F 315		

bowel and bladder, and also that R50 was not using the bathroom due to safety. The CP directed staff to assist R50 "to check and change every 2 hours and PRN" [as needed]. The nursing assistant care sheet "North" unit, undated, also directed for R50: Check and change q 2hrs and PRN [every 2 hours and as needed].

During continuous observation on 7/23/2015 from 7:55 a.m. to 11:12 a.m. (3 hours and 7 minutes) R50 was observed to be dressed and seated upright in her wheel chair, with her right hand and wrist fitted with a splint device, and her right arm was supported and strapped into the arm rest. At 7:55 a.m., R50 was seated in her wheel chair in the living area across from the north unit nursing station and watching a news program on TV. At 8:33 a.m., R50 was wheeled into the dining room and assisted with breakfast, finishing at 9:36 a.m. Following the meal, and still seated in the wheel chair, R50 was moved from the table where food was served to the activity area in the same room. R50 participated in the morning activity, and stayed in the activity area until just after 10 a.m., when a staff member wheeled her into the main entryway of the facility. R50 remained there, still seated in her wheel chair, until 10:19 a.m., when a staff member pushed R50 outside of the building, joining other residents to get fresh air. At 10:37 a.m., R50 was returned into the building near the aviary, and approached by nursing assistant (NA)-F, who after greeting R50, took her vital signs. More than 2 1/2 hours had elapsed since the initial observation, and still R50 was not off loaded, or repositioned out of her wheel chair. R50 remained seated in her wheel chair near the aviary until 11:12 a.m., when NA-F assisted her back to her room. In her room,

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F 315	Continued From page 61	F 315		

NA-F and registered nurse (RN)-B, using the mechanical lift, assisted R50 into her bed. R50 was incontinent of urine, and NA-F provided cleansing cares for her. In the presence of the surveyor, RN-B inspected and assessed R50's skin, and also said R50 was incontinent of urine. R50 was not assisted for toileting from 7:55 a.m. to 11:12 a.m., a total of 3 hours and 7 minutes.

During an interview on 7/23/2015 at 11:16 a.m., nursing assistant (NA)-F stated R50 was last repositioned when she was put in her wheel chair "at about quarter to eight." NA-F then stated R50 was on an "every two hour repo [repositioning] schedule," and that R50 should also be checked for "urinary incontinence."

In an interview on 7/23/2015 at 4:00 p.m. registered nurse (RN)-A stated she would consider resident "who had a stroke to be at risk for pressure sores." RN stated R50 scored "a 13 on the Braden" (a measure for predicting pressure ulcer risk), but that also R50 "had immobility, incontinence, and other risk factors" and was "at risk for pressure." RN-A said she trusted the work group on the floor to get toileting be completed, but what happened today, "I'll say was a fluke."

During an interview on 7/27/2015 at 1:19 p.m., the director of nursing (DON) said the nurse manager had already taken steps to avoid issues when a resident is on a schedule to be turned and checked for incontinence. The DON said in this instance, "[R50] should not go right from breakfast into other activities, that is too long." The DON said resident interventions were care planned, and the facility takes "very seriously, residents' needs for timely assistance."

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F 315	Continued From page 62 A facility policy, Bowel and bladder Program Policy, revised 3/14, indicated as its purpose to "Maintain resident's optimal bowel and bladder continence and maintain skin integrity The policy indicated individual care plan will address "Times to toilet based on individual schedule and/or checking for incontinence."	F 315		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure exhaust fan duct work, lights above grill and screen in the kitchen were clean of dust and debris. This had potential to affect all residents, staff and visitors who consumed food from the kitchen. Findings include: During the initial tour of the facility kitchen with registered dietician (RD) on 7/20/15, at 1:15 p.m.; six metal caged lights above the grill where the food is cooked, were covered with 1/4 inch visible thick dust and debris from the light fixtures. In addition there was a 12 inch long by 6 inch window screen above the kitchen sink which was completely covered in a black dust and debris. An additional tour was completed on 7/21/15, at	F 465	Potential to Affect All Residents, Staff, and Visitors who consume food from the Kitchen 1. Small window was cleaned on 7/21/15 2. Light in hood system was cleaned on 7/21/15 3. Nutrition Services staff was notified of POC at department meeting on 8/18/15 4. Cleaning of hood box will occur monthly. 5. Cleaning of small window will occur monthly. 6. Cleaning procedure for hood box was developed. (Attachment P) Nutrition services staff will be in-serviced on this cleaning procedure at the	8/18/15

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F 465	Continued From page 63 7:30 a.m. the lights and screen were still observed to be covered with visible dust and debris. During interview 7/21/15, at 8:15 a.m. dietary manager (DM) stated the lights were covered in dust along with the screen; the maintenance department was in charge of cleaning these items. The DM stated the maintenance has a staff of 5 and 3 of them are on light duty so things just are not getting done. During interview 7/21/15, at 8:30 a.m. the maintenance manager (MM)-A stated they have a contracted service that cleans the overhead hood vent two times a year. The maintenance director did inspect the lights and the screen and stated "That doesn't cut it" and expressed it is still the expectation to complete needed tasks. Review of the facility contracted cleaning service document form Fire Protection Equipment Co. After Service Follow Up Report dated 9/22/14, indicated the kitchen exhaust system hood was cleaned but not to code due to them being inaccessible. The recommendations indicated to "replacing box-style fan with upblast style to better access duct work." The company was out again on 3/2/15 and the Fire Protection Equipment Co. After Service Follow Up Report recommended "replacing box-style down blast fan with upblast fan to access fan and duct work. Replace damaged filters." During interview 7/22/15, at 2:00 p.m. the MM-A stated the "fan blows down and then diverts the air up to create a vacuum up and out of the roof". The MM-A stated the fans should be cleaned, but that is how this style exhaust fan works and it is	F 465	Department Meeting help on 8/18/15 Monitoring Nutrition Services Manager will conduct an audit on the 4th Monday starting in Aug. & for next six months to ensure this system is being followed and is adequate for keeping the equipment clean. (Attachment Q) Responsibility: Dietary Manager Audit reports will be reported to the Quality Assurance Committee. (QA meets quarterly; Oct., Jan., April and July).	

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F 465	Continued From page 64 grandfathered until we remodel the kitchen at some uncertain time. During phone interview 7/22/15, at 2:15 p.m. with representative from the Fire Protection Equipment Co. stated the fan and ducts are inaccessible because they were unable to see down to the bare metal. The system was very old, which was probably manufactured in 1960's or 70's, and recommended a new unit. The facilities Nutritional Services Cleaning Procedure Equipment Hood policy undated indicated 1. the inside and outside of the hood will be cleaned once per month 2. clean the inside and outside of the hood 3. clean the light fixtures within the hood. Remove the light fixtures and clean with soap 4. use a brush or cloth as needed to remove grease and/or dust 5. wash hood with soap and water 7. the interior section of the hood that extends to the roof is cleansed semi annually by a commercial hood-cleaning operator.	F 465		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
August 10, 2015

Ms. Kim Kucera, Administrator
Mille Lacs Health System
200 North Elm Street
Onamia, Minnesota 56359

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5127025

Dear Ms. Kucera:

The above facility was surveyed on July 20, 2015 through July 23, 2015 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 one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule

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 me.

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,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00374	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

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

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2 000	Continued From page 1 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. On July 20-24 and July 27th, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by:	2 302		

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2 302	Continued From page 3 Based on interview and document review, the facility failed to ensure consumers were provided information regarding Alzheimer's disease and dementia training, including a description of the training program, the categories of employees trained, the frequency of training and the basic topics covered in the training in a written or electronic form. This had the potential to affect all residents and their families. Findings include: During a review of the facility's Alzheimer's training program, there was no information or documentation that indicated the consumers (resident families) were provided a description of Alzheimer's training program, categories of employees trained, frequency of training and the basic topics covered. During an interview on 7/21/15, at 4:07 p.m., the social worker stated, dementia training was completed through educare. She stated she not sure how resident families received this information. The director of nursing (DON) stated, no family education was provided regarding Alzheimers' training, and she was unaware that it was required. SUGGESTED METHOD OF CORRECTION: The DON or designee could add information regarding staff training to the resident admission packet so consumers were aware of this information. The DON or designee could educate staff about this requirement and conduct audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		

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2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care for timely repositioning and toileting assistance for 1 of 1 residents (R50) with urinary incontinence, and at risk for pressure ulcer development. Findings include: R50's diagnoses, as identified on the care plan (CP), reviewed 6/6/2015, included hemiplegia affecting dominant side, dementia, and aphasia due to cerebrovascular disease. The quarterly Minimum Data Set (MDS), dated 5/27/2015, indicated R50 had severely impaired cognition, and was unable to walk. The MDS also identified R50 required extensive, physical assistance for activities of daily living (ADLs), including two-person assist with bed mobility, transfers, toileting, and personal hygiene. R50's care plan (CP) identified the potential for alteration in skin integrity, and also R50's alteration in elimination/toileting. The CP directed staff to follow the mobility plan of care, and assist R50 "to turn and reposition every 2 hours and PRN" [as needed]. Additionally, the CP directed staff to assist R50 "to check and change every 2	2 565		

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2 565	Continued From page 5 hours and PRN" [as needed]. During continuous observation on 7/23/2015 from 7:55 a.m. to 11:12 a.m. (3 hours and 7 minutes) R50 was observed to be dressed and seated upright in her wheel chair. At 7:55 a.m., R50 was seated in her wheel chair in the living area across from the north unit nursing station and watching a news program on TV. At 8:33 a.m., R50 was wheeled into the dining room and assisted with breakfast, finishing at 9:36 a.m. Following the meal, and still seated in the wheel chair, R50 was moved from the table where food was served to the activity area in the same room. R50 participated in the morning activity, and stayed in the activity area until just after 10:00 a.m., when a staff member wheeled her into the main entryway of the facility. R50 remained there, still seated in her wheel chair, until 10:19 a.m., when a staff member pushed R50 outside of the building, joining other residents to get fresh air. At 10:37 a.m., R50 was returned into the building near the aviary, and was approached by nursing assistant (NA)-F, who after greeting R50, took her vital signs. More than 2 1/2 hours had elapsed since R50 was last toileted or repositioned. R50 remained seated in her wheel chair near the aviary until 11:12 a.m., when NA-F assisted her back to her room. In her room, NA-F and registered nurse (RN)-B, using the mechanical lift, assisted R50 into her bed. R50 was incontinent of urine, and NA-F provided perineal care. RN-B assessed R50's skin, which was pink in color, free of any unusual warmth or swelling, there were no reddened areas, and her skin was fully intact. RN-B also said R50 was incontinent of urine. R50 was not toileted or repositioned from 7:55 a.m. to 11:12 a.m., a total of 3 hours and 7 minutes.	2 565		

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2 565	Continued From page 6 During an interview on 7/23/2015 at 11:16 a.m., nursing assistant (NA)-F stated R50 was last repositioned when she was put in her wheel chair "at about quarter to eight." NA-F then stated R50 was on an "every two hour repo [repositioning] schedule," and that R50 should also be checked for "urinary incontinence." NA-F said R50 "Was definitely ready to be repositioned." In an interview on 7/23/2015 at 4:00 p.m. registered nurse (RN)-A said she "trusted the work group on the floor to get toileting and repositioning completed," but what happened today, "I'll say was a fluke." RN-A also stated, "I'll be honest, [R50] should have been turned." During an interview on 7/27/2015 at 1:19 p.m., the director of nursing (DON) said resident interventions were care planned, and the facility takes "very seriously, residents' needs for timely assistance." A facility policy regarding the implementation of care plans was requested, but none provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and / or designee could review the importance of implementing all residents' plan of cares, to assure resident needs are being met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position	2 905		

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2 905	Continued From page 7 must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning for 1 of 2 residents (R50) reviewed in the sample identified at risk for development of pressure ulcers. Findings include: R50's diagnoses, as identified on the care plan (CP), reviewed 6/6/2015, included hemiplegia affecting dominant side, dementia, and aphasia due to cerebrovascular disease. The quarterly Minimum Data Set (MDS), dated 5/27/2015, indicated R50 had severely impaired cognition, and was unable to walk. The MDS also identified R50 required extensive, physical assistance for activities of daily living (ADLs), including two-person assist with bed mobility, transfers, toileting, and personal hygiene. A Braden Pressure Sore Risk Assessment, dated 5/26/2015, indicated R50 was at moderate risk for development of pressure sores. A comprehensive skin assessment summary, dated 5/26/2015, identified R50 required extensive to total assist with ADLs, that she was unable to walk, and was on a turn-and-reposition schedule every 2 hours. The care area assessment (CAA) for pressure ulcers, dated 2/25/2015, identified additional pressure ulcer risk factors for R50 including immobility, incontinence, cognitive loss	2 905		

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2 905	Continued From page 8	2 905		

and functional limitation in range of motion.

R50's CP identified the potential for alteration in skin integrity. The CP directed staff to follow the mobility plan of care, and assist R50 "to turn and reposition every 2 hours and PRN" [as needed]. The nursing assistant care sheet "North" unit, undated, directed for R50: T & R q 2 hrs [turn and reposition every 2 hours].

During continuous observation on 7/23/2015 from 7:55 a.m. to 11:12 a.m. (3 hours and 7 minutes) R50 was observed to be dressed and seated upright in her wheel chair, with her right hand and wrist fitted with a splint device, and her right arm was supported and strapped into the arm rest. At 7:55 a.m., R50 was seated in her wheel chair in the living area across from the north unit nursing station and watching a news program on TV. At 8:33 a.m., R50 was wheeled into the dining room and assisted with breakfast, finishing at 9:36 a.m. Following the meal, and still seated in the wheel chair, R50 was moved from the table where food was served to the activity area in the same room. R50 participated in the morning activity, and stayed in the activity area until just after 10 a.m., when a staff member wheeled her into the main entryway of the facility. R50 remained there, still seated in her wheel chair, until 10:19 a.m., when a staff member pushed R50 outside of the building, joining other residents to get fresh air. At 10:37 a.m., R50 was returned into the building near the aviary, and approached by nursing assistant (NA)-F, who after greeting R50, took her vital signs. More than 2 1/2 hours had elapsed since the initial observation, and still R50 was not off loaded, or repositioned out of her wheel chair. R50 remained seated in her wheel chair near the aviary until 11:12 a.m., when NA-F assisted her back to her room. In her room,

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2 905	Continued From page 9	2 905		

NA-F and registered nurse (RN)-B, using the mechanical lift, assisted R50 into her bed. R50 was incontinent of urine, and NA-F provided cleansing cares for her. In the presence of the surveyor, RN-B inspected and assessed R50's skin. R50's skin was normal pink in color, free of any unusual warmth or swelling, there were no reddened areas, and her skin was fully intact. RN-B also said R50 was incontinent of urine. R50 had not been repositioned from 7:55 a.m. to 11:12 a.m., a total of 3 hours and 7 minutes.

During an interview on 7/23/2015 at 11:16 a.m., nursing assistant (NA)-F stated R50 was last repositioned when she was put in her wheel chair "at about quarter to eight." NA-F then stated R50 was on an "every two hour repo [repositioning] schedule," and R50, "Was definitely ready to be repositioned."

A review of nursing and physician long-term care progress notes from 3/26/2015 to 7/14/2015, indicated R50 did not have, nor was being treated for a current pressure ulcer. During this time, R50 did not develop a pressure ulcer.

In an interview on 7/23/2015 at 4:00 p.m. registered nurse (RN)-A stated she would consider any resident "who had a stroke to be at risk for pressure sores." RN-A also said she would "look at everything" to determine if a resident was at risk to develop a pressure ulcer. RN stated R50 scored "a 13 on the Braden" (a measure for predicting pressure ulcer risk), but that also R50 "had immobility, incontinence, and other risk factors" and was "at risk for pressure." RN-A said she trusted the work group on the floor to get toileting and repositioning completed, but what happened today, "I'll say was a fluke." RN-A also stated, "I'll be honest, she should have been

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2 905	Continued From page 10 turned." During an interview on 7/27/2015 at 1:19 p.m., the director of nursing (DON) said the nurse manager had already taken steps to avoid issues when a resident is on a schedule to be turned and checked for incontinence. The DON said in this instance, "[R50] should not go right from breakfast into other activities, that is too long." The DON said resident interventions were care planned, and the facility takes "very seriously, residents' needs for timely assistance." A facility policy, Treatment and Prevention of Skin Breakdown and Ulcers, reviewed 3/14, indicated "It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity..." and "implement preventive measures..." Further, the policy directed, to "establish and record an individualized turning and repositioning schedule if the resident is immobile." SUGGESTED METHOD OF CORRECTION: The Director of Nursing and / designee could review with care staff residents requiring repositioning for pressure ulcer preventing and healing, and monitor for compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 905		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the	2 910		

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2 910	Continued From page 11 unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely toileting assistance for 1 or 1 residents (R50) who had urinary incontinence. Findings include: R50's diagnoses, as identified on the care plan (CP), reviewed 6/6/2015, included hemiplegia affecting dominant side, dementia, and aphasia due to cerebrovascular disease. The quarterly Minimum Data Set (MDS), dated 5/27/2015, indicated R50 had severely impaired cognition, and was unable to walk. The MDS also identified R50 required extensive, physical assistance for activities of daily living (ADLs), including two-person assist with bed mobility, transfers, toileting, and personal hygiene. A bowel and bladder assessment, dated 2/25/2015, indicated R50 was incontinent of bowel and bladder, and also was not safe to use a commode or toilet due to poor trunk control. Further, the assessment indicated R50 would "be checked for incontinence	2 910		

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2 910	Continued From page 12 q 2hr [every 2 hours] and peri care given after each incontinence episode." The care area assessment (CAA) for urinary incontinence, dated 3/11/2015, indicated R50 had dementia, and past history of cardio-vascular accident (stroke), with right-sided hemiplegia. The CAA also indicated R50 was not a candidate for retraining. R50's CP identified alteration in elimination/toileting, that she was incontinent of bowel and bladder, and also that R50 was not using the bathroom due to safety. The CP directed staff to assist R50 "to check and change every 2 hours and PRN" [as needed]. The nursing assistant care sheet "North" unit, undated, also directed for R50: Check and change q 2hrs and PRN [every 2 hours and as needed]. During continuous observation on 7/23/2015 from 7:55 a.m. to 11:12 a.m. (3 hours and 7 minutes) R50 was observed to be dressed and seated upright in her wheel chair, with her right hand and wrist fitted with a splint device, and her right arm was supported and strapped into the arm rest. At 7:55 a.m., R50 was seated in her wheel chair in the living area across from the north unit nursing station and watching a news program on TV. At 8:33 a.m., R50 was wheeled into the dining room and assisted with breakfast, finishing at 9:36 a.m. Following the meal, and still seated in the wheel chair, R50 was moved from the table where food was served to the activity area in the same room. R50 participated in the morning activity, and stayed in the activity area until just after 10 a.m., when a staff member wheeled her into the main entryway of the facility. R50 remained there, still seated in her wheel chair, until 10:19 a.m., when a staff member pushed R50 outside of the building, joining other residents to get fresh air.	2 910		

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2 910	Continued From page 13 At 10:37 a.m., R50 was returned into the building near the aviary, and approached by nursing assistant (NA)-F, who after greeting R50, took her vital signs. More than 2 1/2 hours had elapsed since the initial observation, and still R50 was not off loaded, or repositioned out of her wheel chair. R50 remained seated in her wheel chair near the aviary until 11:12 a.m., when NA-F assisted her back to her room. In her room, NA-F and registered nurse (RN)-B, using the mechanical lift, assisted R50 into her bed. R50 was incontinent of urine, and NA-F provided cleansing cares for her. In the presence of the surveyor, RN-B inspected and assessed R50's skin, and also said R50 was incontinent of urine. R50 was not assisted for toileting from 7:55 a.m. to 11:12 a.m., a total of 3 hours and 7 minutes. During an interview on 7/23/2015 at 11:16 a.m., nursing assistant (NA)-F stated R50 was last repositioned when she was put in her wheel chair "at about quarter to eight." NA-F then stated R50 was on an "every two hour repo [repositioning] schedule," and that R50 should also be checked for "urinary incontinence." In an interview on 7/23/2015 at 4:00 p.m. registered nurse (RN)-A stated she would consider resident "who had a stroke to be at risk for pressure sores." RN stated R50 scored "a 13 on the Braden" (a measure for predicting pressure ulcer risk), but that also R50 "had immobility, incontinence, and other risk factors" and was "at risk for pressure." RN-A said she trusted the work group on the floor to get toileting be completed, but what happened today, "I'll say was a fluke." During an interview on 7/27/2015 at 1:19 p.m., the director of nursing (DON) said the nurse	2 910		

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2 910	Continued From page 14 manager had already taken steps to avoid issues when a resident is on a schedule to be turned and checked for incontinence. The DON said in this instance, "[R50] should not go right from breakfast into other activities, that is too long." The DON said resident interventions were care planned, and the facility takes "very seriously, residents' needs for timely assistance." A facility policy, Bowel and bladder Program Policy, revised 3/14, indicated as its purpose to "Maintain resident's optimal bowel and bladder continence and maintain skin integrity The policy indicated individual care plan will address "Times to toilet based on individual schedule and/or checking for incontinence." SUGGESTED METHOD OF CORRECTION: The Director of Nursing and / designee could review with care staff residents requiring assistance with toileting, and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by:	21565		

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21565	Continued From page 15 Based on observation, interview and document review, the facility failed to ensure safe self-administration of medications (SAM) for 1 of 1 residents (R63) observed for self-administration of a nebulizer treatment. Findings include: During observation on 7/20/15, at 7:28 p.m. R63 was observed alone in her room with a nebulizer (a drug delivery device used to administer medications in the form of a mist inhaled into the lungs) running, with a face mask. The trained medication aide (TMA)-A who had administered the medicaiton was on the opposite side of the dining room passing medications and assisting other residents in their rooms. R63 remove the mask off her nose and mouth and placed the mask on her chest with the elastic strap still around the back of her neck. The TMA-A walked past R63's room while R63 had the mask on her chest and into the room next to R63 twice. TMA-A made no attempted to check, or reapply the mask to R63's nose and mouth for installation of the medication. At 7:44 p.m. TMA-A entered R63's room turned off the nebulizer and removed the mask from R63's chest. R63's diagnoses included dementia with behavioral disturbances, depression, anxiety, chronic obstructive pulmonary disease (COPD) and congestive heart failure. A cognition care plan dated 6/2/15, indicated R63 was disorientated to time and place and had moderately impaired cognition. The Physician's Orders and the Medication Administration Record (MAR) for 7/15, directed Duoneb to be administered four times a day. A hand written note on the MAR indicated R63 did	21565		

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21565	Continued From page 16 not like the nebulizer mask and to hold the mask in front of her face and let her breathe in that way. A Self Administration of Medication Assessment effective 7/21/15, indicated R63 was not cognitively able to participate in a SAM. During interview on 7/20/15, at 7:50 p.m. TMA-A stated she did not know if R63 could be left alone with the nebulizer. She usually does not leave residents alone with their nebulizer but because it had been so hectic and busy she left R63 alone. On 7/23/15, at 11:20 a.m. registered nurse (RN)-A stated R63 was assessed to not to be left alone to SAM the nebulizer. In the past she would not even allow the mask but now will allow staff to hold the mask in front of her. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and/or designee could review the facility's policy for assessment of residents for the ability for self administration of medications, with the facility staff responsible. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21565		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written	21685		

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21685	Continued From page 17 routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure exhaust fan duct work, lights above grill and screen in the kitchen were clean of dust and debris. This had potential to affect all residents, staff and visitors who consumed food from the kitchen. Findings include: During the initial tour of the facility kitchen with registered dietician (RD) on 7/20/15, at 1:15 p.m.; six metal caged lights above the grill where the food is cooked, were covered with 1/4 inch visible thick dust and debris from the light fixtures. In addition there was a 12 inch long by 6 inch window screen above the kitchen sink was completely covered in a black dust and debris. An additional tour was completed on 7/21/15, at 7:30 a.m. the lights and screen were still observed to be covered with visible dust and debris. During interview 7/21/15, at 8:15 a.m. dietary manager (DM) stated the lights were covered in dust along with the screen and the maintenance department was in charge of cleaning those. The DM stated the maintenance has a staff of 5 and 3 of them are on light duty so things just are not getting done. During interview 7/21/15, at 8:30 a.m. the maintenance manager (MM)-A stated they have a contracted service that cleans the overhead hood vent two times a year. The maintenance	21685		

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21685	Continued From page 18 director did inspect the lights and the screen and stated "That doesn't cut it" and expressed it is still the expectation to complete needed tasks. Review of the facility contracted cleaning service document form Fire Protection Equipment Co. After Service Follow Up Report dated 9/22/14, indicated the kitchen exhaust system hood was cleaned but not to code due to them being inaccessible. The recommendations indicated to "replacing box-style fan with upblast style to better access duct work." The company was out again on 3/2/15 and the Fire Protection Equipment Co. After Service Follow Up Report recommended "replacing box-style down blast fan with upblast fan to access fan and duct work. Replace damaged filters." During interview 7/22/15, at 2:00 p.m. the MM-A stated the "fan blows down and then diverts the air up to create a vacuum up and out of the roof". The MM then stated the fans should be cleaned, but that is how this style exhaust fan works and it is grandfathered until we remodel the kitchen at some uncertain time. During phone interview 7/22/15, at 2:15 p.m. with representative from the Fire Protection Equipment Co. stated the fan and ducts are inaccessible because they were unable to see down to the bare metal. The system was very old, which was probably manufactured in 1960's or 70's, and recommended a new unit. The facilities Nutritional Services Cleaning Procedure Equipment Hood policy undated indicated 1. the inside and outside of the hood will be cleaned once per month 2. clean the inside and outside of the hood	21685		

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21685	Continued From page 19 3. clean the light fixtures within the hood. Remove the light fixtures and clean with soap 4. use a brush or cloth as needed to remove grease and/or dust 5. wash hood with soap and water 7. the interior section of the hood that extends to the roof is cleansed semi annually by a commercial hood-cleaning operator. SUGGESTED METHOD OF CORRECTION: The Administrator and / or designee could review the cleaning schedule within food service and determine the frequency that high areas should be cleaned. TIME PERIOD FOR CORRECTION: Seven (7) days.	21685		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified rising and morning routines for 2 of 8 residents (R50 and R12),who required extensive staff assistance to complete activities of daily living (ADL's).	21805		

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21805	Continued From page 20	21805		

R50's diagnoses, as identified on the care plan (CP), reviewed 6/6/2015, included hemiplegia, dementia, and aphasia. The quarterly Minimum Data Set (MDS), dated 5/27/2015, indicated R50 had severely impaired cognition, required extensive, physical assistance for ADL's, including two-person assist with bed mobility, transfers, toileting, dressing and personal hygiene.

During observation on 7/22/2015 at 7:11 a.m., R50 was lying on her back, in her bed, with her left hand positioned on top of her chest. R50's blanket was at the foot of the bed, pulled onto the resident, exposing R50's left leg, and one could see she already had pants on as she lied in bed. R50 remained in bed until 8:41, when NA-F and NA-G assisted her with morning cares. R50 was already dressed, with pants, socks and shirt, when NA-F removed R50's covers and checked for incontinence, NA-F and NA-G assisted R50 into her wheel chair with use of a mechanical lift. NA-F then brushed her hair, and NA-G assisted in placing R50's hand splint and arm into the wheel chair armrest and R50 was up for the day.

During an interview on 7/22/2015 at 8:38 a.m., NA-G said R50 was already dressed this morning, and we "just needed to get up, out of bed." NA-G said R50 needed "total assistance" dressing, and R50 was not able to verbalize her needs to staff.

In an interview on 7/22/2015 at 9:18 a.m., NA-F acknowledged R50 was dressed this morning when she assisted R50 to get up for the day. NA-F did not know who worked with R50, but said "someone on nights [the night shift] got her dressed," and that was typical for R50's routine. NA-F also said R50 would not be dressed early

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21805	Continued From page 21 on Tuesdays, "because she gets a bath on that day." During an interview on 7/24/2015 at 6:00 a.m., NA-H stated she works on the overnight shift, and routinely got R50 "cleaned up and dressed," but not removed from bed, "the day shift would do that." NA-H stated she does not get R50 dressed on her scheduled bath days. She has a list of residents whom she helped get cleaned and dressed, prior to the end of the night shift. NA-H said "I just need to make sure they are dressed and ready to go. I get them dressed and then put them back to bed; it helps out the morning shift." NA-H said if there was a resident that did not want to get up, she was instructed "to get someone else up." NA-H did add that some of the residents she assisted "liked to get up early," and there were some who simply "were up all night anyway." During an interview on 7/24/2015 at 1:06 p.m., family member (FM)-A said he was unaware staff were getting R50 dressed, then having her stay in bed. FM-A said that depending on the night, R50 was often awake late, or was "up at 3:00 a.m. and restless, and they [staff] will get her up." FM-A than stated, "I would think if [R50] got dressed, she'd be getting out, and up to breakfast for the day." In an interview on 7/24/2015 at 1:17 p.m., the director of nursing (DON) stated the night shift try "to help the day shift staff." The DON said "If someone was trying to get up, then get them up, and keep [the resident] from getting out of bed and possibly fall." In the same interview, the social worker (SW) said getting a resident up during the night was "not just a decision for the aide. We should look into this some more."	21805		

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21805	Continued From page 22 R12's quarterly minimum data set (MDS), dated 5/18/15, indicated she was severely, cognitively impaired and required extensive assist for transfers, dressing and grooming. The care plan (CP), dated 8/28/13, directed staff to give R12 opportunities to make daily preferences choices, including clothing, bed time and bathing. The CP also indicated R12 had an alteration in sleep, related to insomnia, with a goal of at least six hours of sleep at night. The CP did not address a morning routine preference of when R12 wanted to get up. During observation on 7/22/15 at 7:00 a.m., R12 was noted fully dressed and seated in her wheel chair. R12 was positioned in front of the television in the common area on the east wing, asleep in her wheelchair. R12 repeatedly made jerking movements as she dozed. R12 remained in chair until 8:15 a.m., (75 minutes) when staff approached, and awakened her. The staff asked R12 if if she wanted to go back to bed, or eat breakfast. R12 replied "I don't care." During an interview on 7/24/15, at 5:59 a.m., NA-E stated she was instructed to get four residents up, washed and dressed when working the over night shift. NA-E stated if a resident had shower, there was another one assigned to get up in their place. NA-E stated she will usually "get the residents up, washed, dressed and put them back to bed." During an interview on 7/24/15 12:24 p.m., licensed practical nurse (LPN)-C stated, " usually the over night shift is getting up the early risers, she stated they are not getting up anyone that would normally sleep in. LPN-C further stated,	21805		

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21805	Continued From page 23 "Some of the Hoyers [residents who require use of a mechanical lift to transfer] get washed, dressed and put back in bed, I don't have any idea why they would do that." During an interview on 7/24/15, at 1:16 p.m., the director of nursing (DON) stated, there are many people getting up and dressed and put back to bed on the night shift. She stated, The nurses and care coordinators schedule them to help the day shift. The DON further stated, "the people on this list are usually up or crawling out of bed," we like the night shift to help day shift "get a jump on the day." She further stated, "I'm sure we are not the only nursing home in the world that does that." The intent is to help day shift out and prevent falls. The DON stated she was not sure if the rationale for waking a resident on night shift to get them washed and dressed is on the care plan or not. During an interview on 7/24/15, at 2:07 p.m., registered nurse (RN)-C stated, We schedule residents for the night shift to get up, washed and dressed. She stated, We usually look at people who are trying to get up but if there aren't enough people who want to get up, we will pick people who are a "Hoyer lift." The aides will wash and dress them in bed. RN- C stated, "If someone prefers to get up early it is not care planned." She further stated, there is no one currently on the East unit that is care planned to get up early due to fall risk. RN-C stated, The rationale for night shift getting resident's washed and dressed is due to the workload in the morning. Review of the facility's undated East night group sheet directed night shift to complete morning cares, oral cares, dressing, making bed and cleaning up room for five residents on the unit,	21805		

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21805	Continued From page 24 including R12. A review of the facility policy, Rights and Responsibilities of Patients/Residents, dated 4/15, indicated the facility "must, with courtesy, promote care for [residents] in a manner that maintains and enhances dignity and respect in full recognition of [a resident's] individuality." SUGGESTED METHOD OF CORRECTION: The Administrator and/or designee could inservice facility staff in regards to provision of care in a dignified manner. They could create an auditing system to ensure residents are being treated with dignity. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21805		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined	21990		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21990	Continued From page 25 in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure all allegations of abuse, neglect, mistreatment and injuries of unknown were immediately reported to the adminstrator and state agency, were thoroughly investigated, and residents were protected during their investigations for 8 of 15 residents' (R47, R12, R22, R39, R11, R66, R44 and R8) allegations reviewed. The facility failed to conduct reference checks for 4 of 5 newly hired employees (NA-A, NA-B, DA-A and RN-B). Findings include: Investigation and Protection During interview 7/23/15, at 5:09 p.m. with social worker (SW) stated that nursing assistant (NA)-C has been implicated in four incident reports from January 2015 to July 2015 as the potential alleged perpetrator (AP). Review of facility Incident and Investigation reports indicated the following: R47's quarterly Minimum Data Set (MDS) dated 2/17/15, indicated she was moderately cognitively intact and needed extensive assistance in ADLs. R47's care plan dated 2/26/15, indicated she had dementia and needs assist with dressing, grooming and bathing. The care plan further indicated she had slight alteration in cognition related to dementia and that resident will continue to be oriented to person, place and time.	21990		

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Mille Lacs Nursing Home Progress Notes dated 1/24/15, at 3:49 a.m. indicated: "This nurse [LPN-D] was in a res. room, 5 rooms away from where the incident happened, but heard a distinct smack. Followed by a woman's out cry. This nurse then got a call on the walkie [walkie-talkie] from the aide. The aide stated (in her words) On 2 a.m. rounds, I went to check resident in room 45-1 and woke up resident in 45 -2 [R47] in the process. I told [R47] the time and said she should lay back down and try and get some sleep until coffee time. [R47] said "No, I want to sit up I'm waiting." NA-C said "No lets lay down" and NA-C went to pick up [R47's] feet to bring them in bed and [R47] swung and hit me in the head, fairly hard. I [NA-C] yelled out "ow" and NA-C said "why did you hit me, R47 said "I didn't, you hit me you liar" then [NA-C] walked out and walkie the nurse...." This nurse [LPN-D] asked the res. why she hit the aide. Res. [R47] stated that the aide hit her."

An Incident Report submitted to the state agency on 1/28/15, indicated that R47 had a conflict with a nursing assistant on 1/24/15. Following a review of the related progress notes, and supervisory staff, it was originally determined R47's incident was due to her dementia. Further study revealed that R47 allegedly struck a nursing assistant, but resident [R47] also alleged the nursing assistant struck her. The report indicated a further investigation needed to be completed.

A follow-up Investigative Report was submitted to the state agency on 2/2/15. The report indicated the SW met with the resident R47 on the a.m. of 1/28/15 and 1/30/15 and resident was unable to recall any incidents of concerns. The SW was unable to speak with NA-C until 2/2/15 (7 days

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21990	Continued From page 27 after the SW learned of the situation) in part due to her work schedule not coinciding with the SW. SW spoke with NA-C by phone on 2/2/15, at 10:45 p.m. NA-C acknowledged the incident happened as described by LPN-D's note. NA-C stated she had not struck R47 in any way, but had tried to lift R47's legs to help her lay down. The investigative report indicated the AP was NA-C. This report also included that NA-C had been implicated in a previous submitted report. During interview 7/23/15, at 5:10 p.m., the SW stated the resident was unable to recall if the incident had happened, and said R47 had dementia. The SW said NA-C was not suspended during her investigation because it could "not be proved" that NA-C abused R47, and R47 continued to be on the work schedule. The SW said NA-C was counseled on how to provide cares for R47, and was asked for ideas from NA-C on how to keep R47 safe. Review of the facility's MLHS-LTC NA/R Schedule indicated NA-C was not suspended pending the investigation of the incident dated 1/28/15 and NA-C was scheduled to work 1/28/15 and 1/29/15, while the investigation was in progress. The investigation of this incident lacked timely interviewing of the NA-C. This incident occurred on 1/24/15 but was not reported to the SA until 1/27/15. The investigation did not determine if the R47 was actually abused. The facility did not suspend NA-C or take action to protect residents, during the investigation. There was no indication that a thorough investigation was completed for R47.	21990		

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21990	Continued From page 28 R47 had another facility Social Service Incident Referral Form (SSIRF), signed by RN-C indicated R47 was involved in an incident on "3/2/15 early a.m., of possible abuse or resident aggression." The SSIRF indicated: RN-C noted PCC notes (electronic progress notes) by LPN-B questioning verbal statements and other behaviors by resident [R47]; possible indication of maltreatment but just a likely symptoms of resident's dementia." The SSIRF further indicated the incident was discussed with Investigative Team on 3/3/15 at 8:30 a.m., and reported submitted to the state agency on 3/3/2015 at 12:30 p.m. The report also indicated NA-C was a person with credible knowledge of the situation. An initial Incident Report was submitted to the state agency on 3/3/15 regarding possible abuse of R47 on 3/2/15. The report referenced "two progress notes from NOC (night) shift early that a.m. of 3/2 that suggests either some behavioral concerns/dementia symptoms by resident [R47] at work or possible maltreatment of resident by staff." The report indicated uncertainty by staff on whether this was maltreatment, and "SW decided to go ahead and submit the allegation to [state agency]...." A nursing progress note, dated 3/2/215 at 4:03 a.m., written by LPN-B, indicated [R47] was "kicking at staff" and [R47] told staff "she was going to report 'her' to the nurse.." The note also indicated R47 told staff "you go around hitting everyone I heard.." On 3/2/15 at 6:03 a.m., a second progress noted indicated staff went to wipe dry blood off [R47's] lip, and [R47] hit staff. The note continued, that after R47 hit staff, R47 stated "I am going to report you for hitting me."	21990		

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21990	Continued From page 29 Facility documentation did not indicate any action was taken to protect R47 and other residents during this investigation of potential abuse. Documentation of the investigation of this incident did not include determination the cause of R47's bloody lip, and there was no evidence of interview with the nursing assistant who provided cares for R47. The SSRIF also indicated there was no immediate reporting of this incident to the state agency or administrator. A final, Investigative Report was submitted to the state agency on 3/06/15 regarding the incident. The report indicated on 3/2/15 the "resident was interviewed by RN Care Coordinator (RN- A) and this SW. Resident denied remembering anything happening this past weekend during the daytime or the nighttime that upset her in any way.....She denied that anyone hits her or has been mean to her or that she has hit anyone else." The report also indicated "SW communicated with [LPN-B] about progress notes from 3/2/15 during night shift, "indicating the NAR was situating resident in the EZ lift (mechanical lift) to help her to the bathroom per resident's request and the NAR noticed resident's lip had been bleeding apparently cracked from being chapped with dry, winter air. [NA-C] told [R47] she was going wipe the dried blood off, but R47 struck out at NA, causing NA's glasses to dismount from her face." The report indicated NA-C re-approached later and assisted [R47] without incident. Later the same night, the NA was doing rounds and attempted to lift R47's feet back in bed, and resident kicked at NA-C. The report then referenced the allegations made by R47, that she was slapped. The report did not confirm a perpetrator in this incident. The report indicated R47's care plan was reviewed, and suggestions were made on how to approach R47 during	21990		

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cares. The report also indicated LPN-B was coached by the SW and DON on more thorough progress note charting, and further, that staff have been reminded to submit timely incident reports. The report included: "Something is just not resting well with this, and although there is no maltreatment of residents 'substantiated' in this particular incident, SW will continue to keep eyes and ears open for patterns and/or trends in conduct, etc."

Review of the facility's MLHS-LTC NA/R Schedule from February 23, 2015 to March 8, 2015, indicated NA-C was assigned to work 3/2/15 (the night of the alleged incident) and also worked on 3/3/15.

During interview 7/23/15, at 5:30 p.m. the SW stated, in review of this incident, she had "concerns with NA-C" but again could not prove she had really done anything wrong. The facility felt they could not substantiate the allegations against NA-C, and therefore did not warrant a "suspension or discipline" during the investigation. There was no indication that a thorough investigation was completed for R47.

R12's quarterly MDS dated 4/27/15 indicated she was moderately cognitively intact and needed extensive assist with dressing, bathing and grooming. R12's care plan dated 1/31/15, indicated she had potential for abuse from others related to cognitive impairment and limited mobility.

An initial Incident Report submitted to the state agency on 2/18/15, indicated that on 2/18/15, R12 was allegedly slapped, on her cheek, by a staff person who was attempting to administer

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medicine. The AP on the Incident Report was listed as unknown.

A final Investigative Report was submitted to the state agency on 2/23/15, regarding the incident. The report indicated R12 had made numerous allegations, but the only allegation that could be "tracked," was the one about someone slapping [R12] during the administration of Milk of Magnesia (MOM) that morning. Firstly, the report indicated the SW and DON proceeded to seek more information about who would have administered the MOM that morning. Per schedule, LPN-B and NA-C were the persons on duty. At 10:45 p.m. on 2/19/15, the DON and SW met with NA-C, who freely admitted having given MOM to R12 under direction of LPN-B. NA-C said "[R12] didn't want the MOM, and [R12] took the cup and threw the MOM all over." [NA-C] tried to clean it up off the bedding, resident's clothing and her face, using wet wipes." The report indicated NA-C denied slapping R12 in any way, but acknowledged wiping R12's face off with the wet ones. The report indicated, "It is possible this was perceived by [R12] as a slap." The SW asked NA-C to go to resident's room to see if resident could/would or would not identify her as the lady who slapped her, and NA-C agreed to do so. [R12] was sleeping soundly, however, so decided not awaken her. The report indicated "[NA-C's] willingness to go, however, leads SW to believe she [NA-C] is being truthful about not slapping resident." The report then indicated the DON spoke to LPN-B by phone on 2/23/15 at 3:20 p.m. LPN-C admitted asking NA-C to give MOM to R12 due to LPN being occupied elsewhere LPN-C also acknowledged that NA-C did report [R12's] claim of being slapped by a "blonde lady." The report then indicated staff have been alerted to have two

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persons present during cares with this resident and NA-C was instructed not to enter room without a colleague present.

During interview on 7/23/15, at 5:20 p.m. the SW stated she did not suspend NA-C since they could not prove NA-C slapped R12. The SW acknowledged NA-C had been involved in multiple incidents, and had "suspicions" with [NA-C], but did not feel "there was a reason to suspend" or provide disciplinary action to her during this investigation.

The investigation of this incident by the facility did not determine if R12 was slapped, nor was there follow up to have R12 positively identify the nursing assistant who provided cares. Although NA-C was instructed not to enter R12's room without a colleague present, the documentation offered no indication protections were put in place for other residents who were assisted by NA-C during this investigation of this incident, regardless of its outcome.

R22's admission MDS dated 4/24/15, indicated she had depression and a cerebral vascular accident (CVA), was moderately cognitively impaired and needed limited assist with transfers and extensive assist with toileting. R22's care plan dated 5/3/15, indicated she needed assist with toileting and transfers, had history of depression and sadness/isolating self. R22's care plan further indicated she had potential for abuse from others related to her general weakness, aches and pains. The care plan goal indicated "resident will remain safe and have needs met in a safe environment."

During observation on 7/20/15, at 5:54 p.m. R22

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lifted her pant leg and displayed a bruise on her right shin measuring approximately 8 cm (centimeters) x 2 cm.. R22's bruise was black, fading to dark purple in color, with no apparent swelling

In an interview 7/20/15, at 5:54 p.m. R22 stated that she had been treated "roughly by the staff" and there is a staff member who works the night shift that is rough with her. R22 went on to state this staff member had "grabbed her arm when transferring" which caused a large bruise and also stated she had also hit her leg into the metal bar along the bottom of her bed.

The facility submitted an Incident Report to the state agency on 6/27/15, regarding an incident of alleged mistreatment and physical abuse of R22. The report also identified a bruise on R22's top right hand, measuring 5.5 cm x 5 cm, circular in shape; and a second bruise on R22's lower right shin 2.5 cm x 2.5 cm, circular in shape. The report was submitted by RN-D, and indicated that the initial reporter, NA-A, was also the alleged perpetrator in this incident. The report indicated, nursing assistant (NA)-C reported at 5:15 a.m., she had toileted R22, After being toileted, R22 told [NA-C] she was not coming back tonight,and that "some girl hurt her." NA-C asked who, and she [R22] stated she doesn't know who. The report then indicated that registered nurse (RN)-A, followed up with R22 in the morning and asked her to tell her what happened: "Resident reported she is not staying here again tonight and is not going to be treated like this anymore." R22 explained that staff was mad at her during the night for getting up to use the bathroom so many times, and that a "girl grabbed me and threw me into bed." R22 pointed out her hand hurt, and said "this is where she grabbed me," noted a

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bruise on top of right hand measures 5.5 cm (centimeters) x 5 cm circular is shape. R22 also reported when she threw me into bed, "I hit my leg on something metal;" a bruise noted on right outer lower shin measures 2.5 cm x 2.5 cm circular in shape. R22 could not recall who the girl was, nor her name. R22 thought it was around 0400. The report further indicated NA-C was the nursing assistant working on that wing during the night, and LPN-A was the nurse in charge. No other injuries noted, resident was reassured she will remain safe here, NA-C will be removed from working with resident at this time.

An additional Incident Report was submitted to the state agency on 7/1/15, which identified an injury of unknown source on R22's right forearm 8 x 5 cm, reddish purple in color, and oval in shape. The date of incident occurrence was unknown. The report indicated R22 said, "It happened a few days ago."

An Investigative Report was submitted to the state agency on 07/02/15, which combined the two submitted incident reports. The report indicated the DON and social worker SW "have tried to investigate this issue thoroughly and have been unable to substantiate who the alleged perpetrator [AP] is for certain, but have reached a conclusion there is reasonable suspicion a crime may have occurred in the form of assault, and are hence submitting a report also to law enforcement, in accordance with Elder Justice Act." Further, "The details of our internal investigation to the limits of our ability are being submitted to OHFC [Office of Health Facility Complaints] the state agency." The Investigative Report further indicated on 7/1/15, the DON and SW met with the AP, (NA-C) who stated R22 had requested to use the toilet 6-8 times that night

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21990	Continued From page 35 (6/27/15). The report then indicated [SW and DON] "discussed with the AP the number of previous incidences involving this NAR, which can raise red flags re [regarding] her credibility, and she became somewhat defensive, face reddening and voice tightening, saying 'it's because I report things and others don't, so I end up getting in trouble.'" The report further listed, that during an interview 7/2/15 the DON and SW meet with NA-D, who stated she "reported having heard from resident (R22) on 6/30, that [R22] is afraid of the girl with the blonde hair and bangs, that she is not very nice, etc. The blond hair with the bangs fits description of NA-C. The report further included that NA-C had been "implicated in previous reports 75814, 78740, and 79433 with possible "power struggles" with residents, as she tries to perform cares; received coaching in these incidents. NA-C was also involved in report 79866 but was not specifically named as AP." Although R22 had described NA-C as the staff member who had hurt her and NA-C was caring for her and received multiple large bruises, no disciplinary action was taken, NA-C was not suspended pending the investigation. Also, there was no indication that a thorough investigation was completed by the facility to include other interviews with staff and residents. During interview on 7/23/15, at 4:50 p.m. the DON stated she has concerns that NA-C might be doing the accusations, but stated she was not certain. The DON said, "Staff monitor [NA-C] during the night shift," and "we have nurses on that do that." The DON stated the nurses were to report if they notice anything and have concerns. In an interview on 7/23/15, at 5:03 p.m. the SW stated she did not talk with other residents or staff	21990		

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regarding abuse allegations by R22. The DON stated, "I don't generally do that, it's not a witch hunt." The DON said, "Just because their name keeps coming up does not make them guilty." The DON also said there were issues around "data privacy and confidentiality." SW further stated when something regarding abuse allegations come up over the weekend, the nurse on duty initiates the OHFC reporting. The SW said the nurse would talk to the resident, and address any immediate concerns. Regarding NA-C, the SW stated, "At times there have been several residents she is not allowed to care for, but that does change if, during the investigation the allegation is not substantiated." The SW further stated, in regard to NA-C, after the first allegation of abuse, "a lot of coaching was done." The SW also said the coaching for NA-C was "not intensive, and there was no improvement plan initiated and no documentation of education or mentoring done."

During an interview on 7/23/15 at 5:10 p.m., the administrator said, "We have three young people working on nights, we can't suspend; there is not enough staff." The administrator further stated, " I feel the DON and SW did the right thing."

During an interview on 07/23/15, at 5:14 p.m. the DON stated NA-C was not suspended per the facility policy following the allegation made by R22 . She stated, "If I had suspended one, I would have had to suspend all three staff, then who would take care of the residents?"

During an interview on 07/24/15, 5:14 a.m., NA-E stated, " I don't work a lot of overnights unless I am mandated, but I do hear a few things." NA-E stated, "I have heard about people being super wet and I have heard that some of the girls are a

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little rough, but I can't tell you who." She further stated one of the residents mentioned about a girl being rough and leaving bruises. NA-E described the staff member as they were described by the resident and stated the resident said " the girl threw me into the chair because I had to go to the bathroom again." NA-E stated she does not see the nurse a lot on nights.

During interview on 7/24/15, at 5:25 a.m. LPN-H stated she works part time on the night shift. LPN-H stated she has heard from other NAs that NA-C is rough with the residents but had not witnessed it directly. LPN-H stated she was not aware that she was to monitor any staff during the night shift when she works. She further indicated she had heard R12 had reported that NA-C had slapped her and that NA-C no longer works on the North wing and thought the reason was because of the cat; not because she can not take care of any certain residents. She then stated the aides on the night shift don't work together they prefer to work on each unit alone.

INJURIES OF UNKNOWN ORIGIN

R39's annual MDS, dated 3/9/15, indicated she was moderately cognitively impaired. Her care plan, dated 3/30/15, indicated she required extensive assist with all activities of daily living, used a mechanical stand for transfers, and was at risk for abuse related to dementia.

Review of Social Service Incident Report Form, dated 10/7/14, indicated R39 had a large, dark purple bruise on the right upper portion of her buttock and that R39 was unaware of how the bruising occurred. The report indicated R39 had been lowered to floor by staff a few days prior to

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the bruise and indicated that may have caused the injury. The incident further indicated use of anticoagulant medication (used to prevent clotting) , other injuries/incidents over an unspecified times frame, and listed the injury as "minor." The injury was not reported to OHFC.

During an interview on 7/24/15, at 12:54 p.m., the DON)stated, when R39 had been lowered to the floor it would be hard to know if injury occurred during that event but stated, R39 bruised easily due to use of anticoagulant medication so therefore the injury was not considered reportable.

Although R39 was moderately impaired and unable to recall how the bruise occurred, there was no evidence that a more in-depth investigation was completed to determine the actual cause, nor was R39's injury of unknown origin reported to the state agency.

R11's quarterly MDS, dated 4/15/15, indicated she was moderately cognitively impaired. Care plan, dated 6/3/15, indicated R11 required extensive to total assist for all activities of daily living, was cognitively impaired, and at risk for abuse related to depression.

Review of three separate Social Services Incident Report Forms indicated R11 had injuries of unknown origin. An incident form dated 10/21/15, indicated R39 had a bruise to the top of her right hand that was dark purple in color and measured 8 cm x 8 cm. The report further indicated R11 was unable to state how the injury occurred, used blood thinners and described the injury as "minor." Another Social Services Report Form,

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dated 11/4/14, indicated R11 had bruising noted to her left temple and above her left eyebrow, and was unable to state the cause of the injury. A third incident report dated 12/18/14, indicated R11 had a bruise of unknown origin to her left inner knee, dark purple in color, measuring 1 x 1 3/4. (unit of measurement was not indicated). The report further indicated R11 was unable to report the cause of the injury, use of anticoagulant medications, and the injury was considered to be " minor." None of the three bruises were reported to OHFC.

During an interview on 7/24/15, at 12:54 p.m., SW stated, R11 "had more bruising than anyone I have ever known." She stated the bruise on R11's hand may have been caused by "recent trimming of [R11's] nails." Regarding the bruise noted to R11's temple and forehead, SW stated that nursing felt the bruising was due to placement of R11's nebulizer mask, however, SW interviewed R11 who reported that she slipped and fell on her way back from supper. SW further stated R11 did not ambulate, used a Hoyer lift for transfer and there were no records of any falls and indicated the bruising was likely due to placement of R11's nebulizer mask.

During an interview on 7/24/15, at 12:54 p.m., the DON stated R11 could reliably answer when asked if bruising was related to abuse, therefore, she felt the injury was not reportable.

Although R11 was identified to be moderately cognitively impaired, and had multiple bruises at different locations, and were unable to determine what happened, there was no indepth investigation completed to determine the actual causes of R11's bruises. The facility administrator was notified but none of these incidents were

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21990	Continued From page 40 submitted to the state agency. R66's quarterly MDS, dated 1/7/15, indicated she was moderately cognitively impaired. Care plan, dated 2/9/15, indicated R66 required extensive assist of two staff with use of mechanical lift for transfers, at risk for delirium, and at risk for abuse related to depression. During review of a Social Service Incident Referral Form, dated 2/3/15, a facility progress noted indicated R66 had bruising along both arms from her hands to her shoulders. The form further indicated R66 was unable to state the cause of the injury and that the injury was assessed to be "minor." The injury was not reported to OHFC. During an interview on 7/24/15, at 12:54 p.m., SW stated, the bruises were noted while the DON was reviewing a progress note and she spoke with nursing and determined the bruising was assessed to be a minor injury and therefore not reportable to to OHFC. During an interview on 7/24/15, at 12:54 p.m., the DON stated, R66 used a Hoyer lift (mechanical lift) and did not always cooperate in lift, occasionally "flailing her arms." She further stated, R66 was confused and that it would be "hard to say if R66 would have been able to to talk about how the bruising occurred after any time had passed." Although R66 had bilateral bruising from her hands to her shoulders, the injury was unwitnessed and the resident was unable to identify what happened. The facility had not immediately reported the incident to the state agency nor was a thorough investigation	21990		

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21990	Continued From page 41 completed to determine if R66 was "flailing her arms" while using the mechanical lift. R44's annual MDS, dated 6/9/15, indicated she was severely cognitively impaired. Care plan, dated 7/10/15, indicated R44 required extensive assist with activities of daily living, and was at risk for abuse related to short term memory loss and impaired decision making skills. Review of Social Service Incident Referral Form, dated 6/15/15, indicated R44 had a purple bruise on her posterior forearm measuring 6.3 cm x 7 cm that was found during her bath. The incident form indicated R66 did not state the cause of injury and that the injury was determined to be "minor."The bruise was not reported to OHFC. During an interview on 7/24/15, at 12:54 p.m., SW stated, on 8/18/14, staff reported R8 had a bruise measuring 8.5 cm in length between her thumb and forefinger from the base of the thumb to her wrist. She stated the reporting nurse did the initial evaluation and determined the bruising resulted from R8 wringing her hands, and the wringing of her hands was witnessed by staff. She further stated the injury was not reportable due to staff witness of the potential cause. A Social Services Incident Referral form was requested for this injury but was not received. During an interview on 7/24/15, at 12:54 p.m., SW stated when making a determination of whether or not to report an injury to OHFC, she refers to statutes, and uses a decision tree. SW also stated that she looks at whether a resident is able to explain the injury or if someone else saw	21990		

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it, and if there is a history of other recent falls and/or injuries. She further stated, if the nurses indicated minor injury or injury not suspicious in nature or location, it does not need to be reported.

During an interview on 7/24/15, at 12:54 p.m., the DON stated, there was no criteria for determining whether an injury was minor vs major. She further stated, the nurse finding the injuries did initial evaluation to determine the above injuries to be minor. The DON stated she would use the nurses judgement when determining if an injury was minor or major and that the RN in charge followed up on the injuries. However, she stated there was no charting in the clinical record that would show evidence that follow up had been completed.

Even though R44 was assessed to be severely cognitively impaired, had an injury of "unknown" origin, on the posterior of her arm. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency.

R8's quarterly minimum data set (MDS) identified her to be severely cognitively impaired and requiring assist of two staff for activities of daily living. CP dated 5/15/15 indicated R8 required extensive assist for activities of daily living and was at risk for abuse related to diagnosis of dementia.

A review of SSIRF dated 8/18/14, indicated R8 had a bruise measuring 8.5 cm in length between her thumb and forefinger from the base of her

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21990	Continued From page 43 thumb to her wrist. The reporting nurse did the initial evaluation and determined the bruising resulted from R8 wringing her hands, and the wringing of her hands was witnessed by staff. During an interview on 7/24/15, at 12:54 p.m., SW stated, the injury was not reportable due to staff witness of the potential cause. No further investigation of the injury was completed. The facility administrator was notified of the injury but a report was not made to the state agency. A Social Services Incident Referral form was requested for this injury but was not received. Although R8 had severe cognitive impairment, and had a bruise 8.5 cm between her thumb and forefinger from the base of her thumb to her wrist. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency. Review of the facility Vulnerable Adult Policy, revised 7/15, indicated: "It is the policy of MLHS (Mille Lacs Health System) to protect adults who are vulnerable to abuse (including verbal, physical, mental psychosocial/emotional, and sexual abuse)..." The policy further indicated: "protection will include abuse prevention plans, individual abuse prevention plans, internal reporting of all cases of suspected abuse, neglect, or financial exploitation, and external reporting to the Common Entry Point (CEP) of substantiated incidents of maltreatment." In regard to investigation of a reportable incident,	21990		

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21990	Continued From page 44 the policy stated: "All alleged violations are thoroughly investigated. The facility must prevent further potential abuse while the investigation is in progress." Under the "Protection for Resident or Patient" section, the policy directed that "The alleged perpetrator (AP) will be removed from the situation. If the AP is an employee, they will be suspended until the investigation is completed," and further, "Disciplinary action will be carried out up to and including dismissal of employee/employees as appropriate." The Policy defined Injury of Unknown Origin as "...source of the injury was not observed and injury as suspicious." The policy did not expound on this definition top include CMS definitions. In regard to screening of potential employees, the policy directed "MLHS will attempt to obtain information from previous employers and/or current employers." SUGGESTED METHOD OF CORRECTION: The Administrator and/or designee could review and inservice the facility staff responsible for the investigation of allegations of abuse and neglect, to the State rules and facility policy. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21990		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its	22000		

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22000	Continued From page 45 environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult.	22000		

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22000	Continued From page 46 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement their Vulnerable Adult Policy to ensure all allegations of abuse, neglect, mistreatment and injuries of unknown origin were immediately reported to the administrator and state agency, were thoroughly investigated, and residents were protected during the investigations for 8 of 15 residents' (R47, R12, R22, R39, R11, R66, R44 and R8) allegations reviewed. In addition, the facility failed to conduct reference checks according to their policy for 4 of 5 newly hired employees (NA-A, NA-B, DA-A and RN-B). This had the potential to effect all 50 residents who resided in the facility, and resulted in substandard quality of care under resident behavior and facility practices. Findings include: The facility Vulnerable Adult Policy, revised 7/15, indicated: "It is the policy of MLHS (Mille Lacs Health System) to protect adults who are vulnerable to abuse (including verbal, physical, mental psychosocial/emotional, and sexual abuse)..." The policy further indicated: "protection will include abuse prevention plans, individual abuse prevention plans, internal reporting of all cases of suspected abuse, neglect, or financial exploitation, and external reporting to the Common Entry Point (CEP) of substantiated incidents of maltreatment." In regard to investigation of a reportable incident, the policy stated: "All alleged violations are thoroughly	22000		

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22000	Continued From page 47 investigated. The facility must prevent further potential abuse while the investigation is in progress." Under the "Protection for Resident or Patient" section, the policy directed: "The alleged perpetrator (AP) will be removed from the situation. If the AP is an employee, they will be suspended until the investigation is completed," and further, "Disciplinary action will be carried out up to and including dismissal of employee/employees as appropriate." INVESTIGATION AND PROTECTION During interview 7/23/15, at 5:09 p.m. with social worker (SW) stated that nursing assistant (NA)-C has been implicated in at least four incident reports from February 2015 to July 2015 of alleged abuse, and neglect. Review of facility Incident and Investigation reports from 2/1/2015 to 7/20/2015 for NA-C identified the following: R47's quarterly minimum data set (MDS) dated 2/17/15, indicated she was moderately cognitively intact and needed extensive assistance in ADLs. R47's care plan dated 2/26/15, indicated she had dementia and needs assist with dressing, grooming and bathing. The care plan further indicated she had slight alteration in cognition related to dementia and that resident will continue to be oriented to person, place and time. A facility Social Service Incident Referral Form (SSIRF) indicated licensed practical nurse (LPN)-D verbally reported to the social worker (SW) on 1/27/2014, at 4 p.m., an incident that occurred during the night shift on 1/24/2015. The SSIRF, dated 1/27/15, indicated: "Alleged altercation/conflict between res [resident] & aides resulting in resident slapping aide and stating 'I	22000		

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didn't hit you, you hit me you liar.'" The SSIRF also indicated, "LPN separated aide & resident, assisted res to bed, escorted aide to hallway to inquire what happened." The SSIRF also indicated the incident required "further investigation and/or reporting" to the state agency, and this was signed by the SW on 1/28/15.

A review of Mille Lacs Nursing Home Progress Notes, dated 1/28/15, written by LPN-D indicated: "This nurse was in a res. room, 5 rooms away from where the incident happened, but heard a distinct smack. Followed by a woman's out cry. This nurse then got a call on the walkie [walkie-talkie] from the aide (nursing assistant, NA)." The [NA] stated (in her words) "On 2 a.m. rounds, I went to check resident in room 45-1 (room 45, bed 1) and woke up resident in 45-2 [R47] in the process. I told [R47] the time and said she should lay back down and try and get some sleep until coffee time." [R47] said "No, I want to sit up I'm waiting." NA said "No lets lay down" and NA went to pick up [R47's] feet to bring them in bed and [R47] swung and hit me in the head, fairly hard. I [NA] yelled out "ow" and NA said "why did you hit me, [R47] said, 'I didn't, you hit me you liar' then [NA] walked out and walkie the nurse...." This nurse [LPN-D] asked the res. why she hit the aide. Res. [R47] stated that the aide hit her." The nursing note did not identify the nursing assistant by name.

A facility email, written by the SW, dated 1/28/2015, indicated the SW had been verbally informed by LPN-D of R47 being in a conflict with a nursing assistant. The email indicated there was a progress note of the incident, but no further "incident report form." The email indicated the SW further reviewed the progress notes, and

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because the notes indicated "the resident allegedly struck a NAR [nursing assistant] and also that the resident claimed at the time that the NAR struck her, the incident DOES need to be reported" to the state agency.

An Incident Report submitted to the state agency on 1/28/15, indicated: "An incident was verbally reported to this SW in the late afternoon 1/27/15..." and further that R47 had a conflict "this past weekend" with a nursing assistant. Following a review of the related progress notes by the "Stand Up Team" and "Behavior Management Team", it was originally determined incident was due to [R47's] "dementia symptoms..." The report referred to a nursing progress note which indicated that [R47] "claimed at the time that the NAR struck her," thus requiring a report to the state agency, and "an internal investigation done accordingly as per policy." The alleged perpetrator (AP) was unidentified.

A review of the SSIRF, the internal email, and the initial report submitted to the state agency indicated an incident occurred sometime during the night shift/early morning hours of 1/25/14. The report also indicated the incident was first reported, and made known to the SW on late afternoon of 1/27/2014, (two days after the incident) and reported to the state agency on 1/28/2015 (three days after the incident allegedly occurred). There was no indication this incident was reported immediately to the administrator and state agency. Additionally, the investigation of this incident: lacked timely interviewing of NA-C, and other involved staff, and potentially affected residents; did not provide evidence R47 was thoroughly investigated for injuries; and lacked evidence of action to protect residents

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22000	Continued From page 50 during the investigation. A final Investigative Report was submitted to the state agency on 2/2/15. The report indicated the SW met with R47 "on the a.m. of 1/28/15 and 1/30/15," and "Resident unable to recall any incidents of concern with any aides the previous weekend." The SW was unable to speak with NA-C, (identified as the nursing assistant involved) until 2/2/15 (7 days after the SW learned of the incident) "in part due to her work schedule not coinciding with the SW." SW spoke with NA-C by phone on 2/2/15, at 10:45 p.m. NA-C "acknowledged the incident happened as described" by LPN-D's note, and further, "[NA-C] saying she had not struck resident in any way, but had merely tried to lift [R47's] legs to help her lay back down..." The report indicated "There is no apparent evidence of NAR striking resident." The investigative report indicated the alleged perpetrator was NA-C. This report also included that NA-C had been implicated in a previous submitted report. During an interview 7/23/15, at 5:10 p.m., the SW stated in the investigation, R47 was unable to recall if the incident had happened, and that R47 had dementia. The SW said NA-C was not suspended during her investigation because it could not be proven that NA-C abused R47, and NA-C continued to be on the work schedule. The SW said NA-C was counseled on how to provide cares for R47, and was asked for ideas from NA-C on how to keep R47 safe. Review of the facility's MLHS-LTC NA/R Schedule from January 26, 2014 to February 8, 2015, indicated NA-C worked on the night shift on 1/28/15 and 1/29/15, while the investigation of	22000		

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22000	Continued From page 51 this incident was in progress. R47 had another facility Social Service Incident Referral Form (SSIRF), signed by RN-C indicated R47 was involved in an incident on "3/2/15 early a.m., of possible abuse or resident aggression." The SSIRF indicated: RN-C noted PCC notes (electronic progress notes) by LPN-B questioning verbal statements and other behaviors by resident [R47]; possible indication of maltreatment but just a likely symptoms of resident's dementia." The SSIRF further indicated the incident was discussed with Investigative Team on 3/3/15 at 8:30 a.m., and reported submitted to the state agency on 3/3/2015 at 12:30 p.m. The report also indicated NA-C was a person with credible knowledge of the situation. An initial Incident Report was submitted to the state agency on 3/3/15 regarding possible maltreatment of R47 on 3/2/15. The report referenced "two progress notes from NOC (night) shift early that a.m. of 3/2 that suggests either some behavioral concerns/dementia symptoms by resident [R47] at work or possible maltreatment of resident by staff." The report indicated uncertainty by staff on whether this was maltreatment, and "SW decided to go ahead and submit the allegation to [state agency]...." A nursing progress note, dated 3/2/215 at 4:03 a.m., written by LPN-B, indicated [R47] was "kicking at staff" and [R47] told staff "she was going to report 'her' to the nurse.." The note also indicated R47 told staff "you go around hitting everyone I heard.." On 3/2/15 at 6:03 a.m., a second progress noted indicated staff went to wipe dry blood off [R47's] lip, and [R47] hit staff.	22000		

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22000	Continued From page 52 The note continued, that after R47 hit staff, R47 stated "I am going to report you for hitting me." Facility documentation did not indicate any action was taken to protect R47 and other residents during this investigation of potential abuse. Documentation of the investigation of this incident did not include determination the cause of R47's bloody lip, and there was no evidence of interview with the nursing assistant who provided cares for R47. The SSRIF also indicated there was no immediate reporting of this incident to the state agency or administrator. A final, Investigative Report was submitted to the state agency on 3/06/15 regarding the incident. The report indicated on 3/2/15 the "resident was interviewed by RN Care Coordinator (RN- A) and this SW. Resident denied remembering anything happening this past weekend during the daytime or the nighttime that upset her in any way.....She denied that anyone hits her or has been mean to her or that she has hit anyone else." The report also indicated "SW communicated with [LPN-B] about progress notes from 3/2/15 during night shift, "indicating the NAR was situating resident in the EZ lift (mechanical lift) to help her to the bathroom per resident's request and the NAR noticed resident's lip had been bleeding apparently cracked from being chapped with dry, winter air. [NA-C] told [R47] she was going wipe the dried blood off, but R47 struck out at NA, causing NA's glasses to dismount from her face." The report indicated NA-C re-approached later and assisted [R47] without incident. Later the same night, the NA was doing rounds and attempted to lift R47's feet back in bed, and resident kicked at NA-C. The report then referenced the allegations made by R47, that she was slapped. The report did not confirm a	22000		

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perpetrator in this incident. The report indicated R47's care plan was reviewed, and suggestions were made on how to approach R47 during cares. The report also indicated LPN-B was coached by the SW and DON on more thorough progress note charting, and further, that staff have been reminded to submit timely incident reports. The report included: "Something is just not resting well with this, and although there is no maltreatment of residents 'substantiated' in this particular incident, SW will continue to keep eyes and ears open for patterns and/or trends in conduct, etc."

Review of the facility's MLHS-LTC NA/R Schedule from February 23, 2015 to March 8, 2015, indicated NA-C was assigned to work 3/2/15 (the night of the alleged incident) and also worked on 3/3/15.

During interview 7/23/15, at 5:30 p.m. the SW stated, in review of this incident, she had "concerns with NA-C" but again could not prove she had really done anything wrong. The facility felt they could not substantiate the allegations against NA-C, and therefore did not warrant a "suspension or discipline" during the investigation. There was no indication that a thorough investigation was completed for R47.

R12's quarterly MDS dated 4/27/15 indicated she was moderately, cognitively intact and needed extensive assist with dressing, bathing and grooming. R12's care plan dated 1/31/15, indicated she had potential for abuse from others related to cognitive impairment and limited mobility.

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22000	Continued From page 54 A facility Social Service Incident Referral Form (SSIRF), signed by the SW 2/18/15 at 4:15 p.m., indicated there was an incident on "2/18/2015 early A.M.", which alleged "Abuse." The incident was described as: "[NA)-I] asked SW to meet w/ Res re some issues. 9:30 a.m. Res told SW 'I want to go home, they're mean to me here.' 'The lady with the ponytail hurt me when she clean me up yesterday', and 'The other lady slapped me when she tried to make me drink white stuff.' At 4p.m. resident [R12] was still claiming similar concerns." The SSIRF also indicated the following: an internal email report was completed on 2/18/15; that the report of alleged abuse was received by the SW in person, no date or time listed; the incident was discussed with "Investigative Team" on 2/18/15 at 0833; and that the state agency initial report was submitted on 2/18/15 (no time indicated). An initial Incident Report submitted to the state agency on 2/18/15, indicated on 2/18/15, R12 was "slapped on her cheek by a staff person early this morning while staff person was trying to get her to take some medicine." The report indicated R12 had no apparent injuries, and "has been consistent with this claim throughout the day..." The report also indicated "a full internal investigation is warranted." The "alleged perpetrator" on the report form was listed as "unknown." A review of the SSIRF, and the initial report to the State Agency indicated, that although this incident occurred in the early morning of 2/18/15, and possibly earlier, no action was taken by the facility or staff until it was discussed later that morning on 2/18/15. There was no indication the incident was immediately reported to state agency and administrator. Further, the investigation	22000		

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documentation of this incident did not indicate if R12 was slapped; and there was no follow up to have R12 positively identify the nursing assistant, (possibly NA-C) who provided her cares that day. Although NA-C was instructed not to enter R12's room without a colleague present, the documentation offered no indication protections were put in place for other residents who were assisted by NA-C during the investigation of this incident, regardless of its outcome.

A final Investigative Report was submitted to the state agency on 2/23/15. The final report indicated the "Initial Reports submitted to [state agency] ...at 4 p.m.," on 2/18/15, and also a call was made to local law enforcement. The report indicated R12 had made numerous allegations, but the only allegation that could be "tracked, was the one about someone slapping her during the administration of Milk of Magnesia (MOM) that morning (the white stuff)." The report indicated SW and DON proceeded to seek more information about who would have administered the MOM that morning. The report identified, according to the schedule, LPN-B and NA-C were the persons on duty. Further, the report indicated, "DON and SW met with [NA-C], who freely admitted having given MOM upon the direction of [LPN-B]." The report continued, "[NA-C] said resident didn't want the MOM, and resident took the cup and threw the MOM all over." and "[NA-C] tried to clean it up off the bedding, resident's clothing and her face, using wet wipes." The report indicated "[NA-C] denied slapping resident in any way, but acknowledged wiping R12's face off with the wet ones." The report indicated "It is possible this was perceived by [R12] as a slap." Next, the report indicated, the SW asked NA-C to go to resident's room to

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see if resident could or would identify her as the lady who slapped her, and NA-C agreed to do so. "[R12] was sleeping soundly, however, so decided not awaken her." The report indicated "NA-C's willingness to go, however, leads SW to believe she [NA-C] is being truthful about not slapping resident." The report indicated the DON spoke to LPN-B by phone on 2/23/15 at 3:20 p.m. LPN-C admitted asking NA-C to give MOM to R12 due to LPN-C being occupied elsewhere LPN-C also acknowledged that NA-C did report (R12's) claim of being slapped by a "blonde lady." The report then indicated staff have been alerted to having "two persons present" during cares with this resident and NA-C was instructed not to enter room without a colleague present.

During interview on 7/23/15, at 5:20 p.m. the SW stated she did not suspend NA-C since "they could not prove [NA-C] slapped [R12.]" The SW acknowledged NA-C had been involved in multiple incidents, and had "suspicions" with [NA-C], but did not feel "there was a reason to suspend" or provide disciplinary action to her during this investigation.

Review of the facility's MLHS-LTC NA/R Schedule from February 9, 2015 to February 22, 2015, indicated NA-C worked on 2/17/15 through 2/22/2015, that is on the date of the alleged incident, and during the subsequent investigation. There was no indication a thorough investigation was completed for R12.

R22's admission MDS dated 4/24/15, indicated she had depression and a cerebral vascular accident (CVA), and was moderately cognitively impaired and needed limited assist with transfers

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22000	Continued From page 57 and extensive assist with toileting. R22's care plan dated 5/3/15, indicated she needed assist with toileting and transfers, had history of depression and sadness/isolating self. R22's care plan further indicated she had potential for abuse from others related to her general weakness, aches and pains. The care plan goal indicated "resident will remain safe and have needs met in a safe environment." During observation on 7/20/15 at 5:54 p.m., R22 lifted her pant leg and displayed a bruise on her right shin measuring approximately 8 cm (centimeters) x 2 cm. R22's bruise was noted to be black, fading to dark purple in color, with no apparent swelling. In an interview 7/20/15, at 5:54 p.m. R22 stated that she had been treated "roughly by the staff" and there is "a staff member who works the night shift that is rough with her." R22 went on to state this staff member had "grabbed her arm when transferring" which caused a large bruise and also stated she had also hit her leg into the metal bar along the bottom of her bed. The facility submitted an Incident Report to the state agency on 6/27/15 regarding an incident of alleged mistreatment and physical abuse of R22. The report also identified a bruise on R22 top right hand, measuring 5.5 cm x 5 cm, circular in shape; and a second bruise on R22's lower right shin 2.5 cm x 2.5 cm, circular in shape. The report was submitted by RN-D, and indicated that the initial reporter, NA-C, was also the alleged perpetrator in this incident. The report indicated, nursing assistant (NA)-C reported at 5:15 a.m., she had toileted R22, after being toileted, R22 told [NA-C] she was not coming back tonight,and that "some girl hurt her." NA-C asked who, and she [R22] stated she doesn't know who. The	22000		

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report then indicated that registered nurse (RN)-A, followed up with R22 in the morning and asked her to tell her what happened: "Resident reported she is not staying her again tonight and is not going to be treated like this anymore." R22 explained that staff was mad at her during the night for getting up to use the bathroom so many times, and that a "girl grabbed me and threw me into bed." R22 pointed out her hand hurt, and said "this is where she grabbed me," noted a bruise on top of right hand measures 5.5 cm (centimeters) x 5 cm circular is shape. R22 also reported when she threw me into bed, "I hit my leg on something metal" a bruise noted on right outer lower shin measures 2.5 cm x 2.5 cm circular in shape. R22 could not recall who the girl was, nor her name. R22 thought it was around 0400. The report further indicated NA-C was the nursing assistant working on that wing during the night, and LPN-A was the nurse in charge. No other injuries noted, resident was reassured she will remain safe here, NA-C will be removed from working with resident at this time.

An additional Incident Report was submitted to the state agency on 7/1/15, which identified an injury of unknown source on R22's right forearm "8 x 5 cm, reddish purple in color and oval in shape." The date of incident occurrence was unknown. The report indicated R22 said "It happened a few days ago."

An Investigative Report was submitted to the state agency on 07/02/15, which combined two submitted incident reports dated 6/27/15 and 7/1/15. The report indicated the director of nursing (DON) and social worker (SW) "have tried to investigate this issue thoroughly and have been unable to substantiate who the alleged perpetrator [AP] is for certain, but have reached a

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22000	Continued From page 59 conclusion there is reasonable suspicion a crime may have occurred in the form of assault, and are hence submitting a report also to law enforcement, in accordance with Elder Justice Act." Further the report indicated, "The details of our internal investigation to the limits of our ability are being submitted to OHFC and the state agency." The Investigative Report further indicated on 7/1/15, the DON and SW met with the AP, (NA-C) who stated R22 had requested to use the toilet 6-8 times that night (6/27/15). The report then indicated [SW and DON] "discussed with the AP the number of previous incidences involving this NAR, which can raise red flags re her credibility, and she became somewhat defensive, face reddening and voice tightening, saying 'it's because I report things and others don't, so I end up getting in trouble.' " The report further listed, that during an interview 7/2/15 the DON and SW meet with NA-D, who stated she "reported having heard from resident (R22) on 6/30, that [R22] is afraid of the girl with the blonde hair and bangs, that she is not very nice, etc. The blond hair with the bangs fits description of NA-C. The report further included that NA-C had been "implicated in previous reports 75814, 78740, and 79433 with possible "power struggles" with residents, as she tries to perform cares; received coaching in these incidents. NA-C was also involved in report 79866 but was not specifically named as AP." Although R22 had described NA-C as the staff member who had hurt her and NA-C was caring for her and received multiple large bruises, the incident documentation indicated no action taken to protect residents during investigation of these incidents. Also, there was no indication that a thorough investigation was completed that included other interviews with staff and residents.	22000		

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22000	Continued From page 60 During interview on 7/23/15, at 4:50 p.m. the DON stated she "has concerns that NA-C might be doing the accusations," but stated she "was not certain." The DON said, "staff monitor [NA-C] during the night shift," and also "we have nurses on that do that." The DON stated the nurses were to report to her if they notice anything and have concerns. In an interview on 7/23/15, at 5:03 p.m., the SW stated she "did not talk with other residents or staff regarding abuse allegations by [R22]." The DON stated, "I don't generally do that, it's not a witch hunt." The DON said, "Just because their name keeps coming up does not make them guilty." The DON also said there were issues around "data privacy and confidentiality." SW further stated, when something regarding abuse allegations come up over the weekend, the nurse on duty initiates the OHFC reporting. The SW said the nurse would talk to the resident, and address any immediate concerns. Regarding NA-C, the SW stated, "At times there have been several residents she is not allowed to care for, but that does change if, during the investigation the allegation is not substantiated." The SW further stated, in regard to NA-C, after the first allegation of abuse, " a lot of coaching was done." The SW also said the coaching for NA-C was "not intensive, and there was no improvement plan initiated and no documentation of education or mentoring done." During an interview on 7/23/15 at 5:10 p.m., the administrator said, "We have three young people working on nights, we can't suspend; there is not enough staff." The administrator further stated, " I feel the DON and SW did the right thing."	22000		

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22000	Continued From page 61 During an interview on 07/23/15, at 5:14 p.m., the DON stated NA-C was not suspended per the facility policy following the allegation made by R22 . She stated, "If I had suspended one, I would have had to suspend all three staff, then who would take care of the residents?" During an interview on 07/24/15 5:14 a.m., NA-E stated, " I don't work a lot of overnights unless I am mandated, but I do hear a few things." NA-E stated, "I have heard about people being super wet and I have heard that some of the girls are a little rough, but I can't tell you who." She further stated, one of the resident mentioned about a girl being rough and leaving bruises. NA-E described the staff member as they were described by the resident and stated the resident said " the girl threw me into the chair because I had to go to the bathroom again." NA-E stated she does not see the nurse a lot on nights. During interview on 7/24/15, at 5:25 a.m. LPN-H stated she works part time on the night shift. LPN-H stated she has heard from other NAs that NA-C is rough with the residents but had not witnessed it directly. LPN-H stated she is not aware that she is to monitor any staff during the night shift when she works. She further indicated she had heard R12 had reported that NA-C had slapped her and also that NA-C no longer works on the North wing and thought the reason was because of the cat not because she can not take care of any certain residents. She then stated the aides on the night shift don't work together they prefer to work on each unit alone. INJURIES OF UNKNOWN ORIGIN The facility Vulnerable Adult Policy, revised 7/15, defined Injury of Unknown Origin as "...source of	22000		

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22000	Continued From page 62	22000		

the injury was not observed and injury as suspicious." The policy did not expound on this definition to include criteria from the CMS interpretive guidance.

R39's annual MDS, dated 3/9/15, indicated she was moderately, cognitively impaired. The CP, dated 3/30/15, indicated R39 required extensive assist with all activities of daily living (ADLs), used a mechanical stand for transfers, and was identified at risk for abuse, because of dementia.

A review of SSIRF dated 10/7/14, indicated R39 had a large, dark purple bruise on the right upper portion of her buttock, and it was an "unknown" injury, and R39 was "unaware" of how the bruising occurred. The SSIRF also indicated R39 "a few days ago had been lowered to floor due to not standing when transferring & then lifted with Hoyer (a mechanical lift) Possible cause." The SSRIF further indicated R39 used a medication that could explain bruising, and also that R39's chart contained "falls or other recent incidents that could likely have produced the injury." The SSIRF indicated R39's injury was "minor" and not reported to the state agency. No further investigation was completed for this incident even though there was no indication R39 had struck any objects or the floor as she was lowered to the ground.

During an interview on 7/24/15, at 12:54 p.m., the DON stated, when R39 had been lowered to the floor "it would be hard to know if injury occurred during that event." The DON said R39 bruised easily due to use of anticoagulant medication, so therefore the injury was "not considered reportable."

Although R39 was moderately impaired and

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
22000	Continued From page 63 unable to recall how the bruise occurred, there was no evidence that a more in-depth investigation was completed to determine the actual cause, nor was R39's injury of unknown origin reported to the state agency. R11's quarterly MDS, dated 4/15/15, indicated she was moderately, cognitively impaired. The CP, dated 6/3/15, indicated R11 required extensive to total assist for all ADLs, and was at risk for abuse related to depression. A review of SSIRF dated 10/21/15, indicated R39 had a bruise to the top of her right hand, dark purple in color, and measured 8 cm x 8 cm. The SSIRF indicated R11 was unable to state how the injury occurred, but R11 used anticoagulant medication, and R11's bruise was described as "minor." The facility administrator was notified but no report was made to the state agency. A second SSIRF, dated 11/4/14, indicated R11 had bruising noted to her left temple and above her left eyebrow. The SSIRF indicated R11 was unable to state the cause of the injury. The facility administrator was notified, but the injury was not reported to the state agency. A third SSIRF dated 12/18/14, indicated R11 had a bruise of unknown origin to her left inner knee, dark purple in color, and measuring 1 x 1 3/4 inches. The SSIRF indicated the injury was "unknown", that R11 was unable to report the cause of the injury, used anticoagulants; and also indicated the injury was considered to be "minor." The facility administrator was notified, but the injury was not reported to the state agency.	22000		

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22000	Continued From page 64 During an interview about the three injuries of unknown origin on 7/24/15, at 12:54 p.m., the SW stated, R11 "had more bruising than anyone I have ever known." The SW said the bruise on R11's hand "may have been caused by recent trimming of [R11's] nails," indicating R11 caused the bruise herself. Regarding the bruise noted to R11's temple and forehead, the SW stated that nursing felt the bruising "was due to placement of [R11's] nebulizer mask," however, the SW stated, she interviewed R11 who reported that she slipped and fell on her way back from supper. SW further stated R11 did not ambulate, used a Hoyer lift [a mechanical lift] for transferring, and there were no records of any falls. SW added the bruising was "likely due to placement of [R11's] nebulizer mask." No further investigation was completed for this injury. During an interview on 7/24/15, at 12:54 p.m., the DON stated R11 "could reliably answer" when the reporting nurse asked if bruising was related to abuse, therefore, the DON felt the injury was not reportable. Although R11 was identified to be moderately cognitively impaired, and had multiple bruises at different locations, there was no indepth investigation completed to determine the actual causes of R11's bruises. The facility administrator was notified of the injuries but none of these incidents were submitted to the state agency. R66's quarterly MDS, dated 1/7/15, indicated she was moderately, cognitively impaired. The CP, dated 2/9/15, indicated R66 required extensive assist of two staff, with use of a mechanical lift, for transfers. The CP also indicated R66 was at	22000		

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22000	Continued From page 65 risk for delirium and potential abuse, related to depression. A review of SSIRF dated 2/3/15, indicated during a review of R66's nursing progress note dated 1/26/2015, there was "presence of unknown bruises" on [R66] both arms, the size was identified as bruising "from hands to shoulder." The SSIRF also indicated R66 now wore sleeve/arm protectors. The SSIRF indicated this was an "unknown injury", that R66 was unable to state the cause, and that the injury was assessed to be "minor." The injury was reported to the facility administrator, but was not not reported to the state agency. During an interview on 7/24/15, at 12:54 p.m., the SW stated, the bruises were noted while the DON was reviewing R66's progress notes. The SW said she "spoke with nursing" and determined the bruising was assessed "to be a minor injury, and therefore not reportable to the state agency." During an interview on 7/24/15, at 12:54 p.m., the DON said R66 used a Hoyer lift (mechanical lift), and R66 did not always cooperate in lift, occasionally "flailing her arms." The DON further stated R66 was confused, and that it would be "hard to say if R66 would have been able to to talk about how the bruising occurred after any time had passed." Although R66 had bilateral bruising from her hands to her shoulders, the injury was unwitnessed and the resident was unable to identify what happened. The facility had not immediately reported the incident to the state agency nor was a thorough investigation completed to determine if R66 was "flailing her arms" while using the mechanical lift.	22000		

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22000	Continued From page 66 R44's annual MDS, dated 6/9/15, indicated she was severely cognitively impaired. The CP, dated 7/10/15, indicated R44 required extensive assist with ADLs, and was at risk for abuse, related to short term memory loss and impaired decision-making skills. A review of SSIRF dated 6/15/15, indicated R44 had a purple bruise on her posterior (back side) forearm, measuring 6.3 cm x 7 cm, that was found during her bath. The SSIRF indicated this was an "unknown" injury, and R66 could not state the cause of injury. The injury was determined to be "minor". The facility administrator was notified, but the injury was not reported to the state agency. During an interview on 7/24/15, at 12:54 p.m., the SW stated, "The injury was determined by nursing staff to be 'minor' and did not meet any suspicious criteria. The SW said she "did not see a need to report" to the state agency. In an interview on 7/24/15, at 12:54 p.m., the DON stated, "[R44] would have been able to tell you if something happened, she could make her needs known." Even though R44 was assessed to be severely cognitively impaired, had an injury of "unknown" origin, on the posterior of her arm. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency.	22000		

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22000	Continued From page 67 R8's quarterly minimum data set (MDS) identified her to be severely cognitively impaired and requiring assist of two staff for activities of daily living. CP dated 5/15/15 indicated R8 required extensive assist for activities of daily living and was at risk for abuse related to diagnosis of dementia. A review of SSIRF dated 8/18/14, indicated R8 had a bruise measuring 8.5cm in length between her thumb and forefinger from the base of her thumb to her wrist. The reporting nurse did the initial evaluation and determined the bruising resulted from R8 wringing her hands, and the wringing of her hands was witnessed by staff. During an interview on 7/24/15, at 12:54 p.m., SW stated, the injury was not reportable due to staff witness of the potential cause. No further investigation of the injury was completed. The facility administrator was notified of the injury but a report was not made to the state agency. A Social Services Incident Referral form was requested for this injury but was not received. Although R8 had severe cognitive impairment, and had a bruise 8.5cm between her thumb and forefinger from the base of her thumb to her wrist. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency. During an interview on 7/24/15, at 12:54 p.m., SW stated, when making a determination of whether or not to report an injury to the state agency, she "refers to statutes, and uses a	22000		

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22000	Continued From page 68 decision tree." The SW also stated that she looks at whether a resident is able to explain the injury, or if someone else saw it, and if there was a history of other recent falls and/or injuries. The SW further stated, "If the nurses indicated minor injury or injury not suspicious in nature or location, it does not need to be reported." During an interview on 7/24/15, at 12:54 p.m., the DON said, minor injuries are not reportable to the state agency. She further stated, there was "no criteria or policy" the facility has to identify and determine whether an injury was "minor" versus "major." The DON also stated she "would use the nurses judgement" when determining if an injury was minor or major, and that the RN in charge "followed up on the injuries." However, she stated there was no charting on the clinical record that would show evidence that follow-up had been completed. REFERENCE CHECKS The facility's Abuse Prevention Policy, revised 7/15, indicated as its purpose "...to protect adults who are vulnerable to abuse..." Further, the policy included: "To assure the facility was doing everything within its control to prevent the occurrence of abuse or neglect...the facility would attempt to obtain information from previous employers and or/current employers." NA-A's personnel record identified they were hired on 7/13/15. The personnel record lacked evidence reference checks were completed prior to employment at the facility. NA-B's personnel record identified they were hired on 6/30/15. The personnel record lacked evidence reference checks were completed prior to employment at the facility.	22000		

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22000	Continued From page 69 Dietary Aide (DA)-A's personnel record identified they were hired on 6/23/15. The personnel record lacked evidence reference checks were completed prior to employment at the facility. Registered nurse (RN)-B's personnel record identified they were hired on 5/11/15. The personnel record lacked evidence reference checks were completed prior to employment at the facility. On 7/23/15, at 8:45 a.m. human resources (HR) staff stated four of the five newly hired employees did not have documentation of reference checks. HR stated there was "not a process" to document that reference checks had been completed. They facility used the application references "to inquire about the position held, date of hire, eligibility for rehire and any feedback." SUGGESTED METHOD OF CORRECTION: The Administrator and/or designee could review and inservice facility staff to their policy in regard to abuse and neglect TIME PERIOD FOR CORRECTION: Fourteen (14) days.	22000		

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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: 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/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 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. On July 20-24 and July 27th, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by:	2 302		8/18/15

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2 302	Continued From page 3 Based on interview and document review, the facility failed to ensure consumers were provided information regarding Alzheimer's disease and dementia training, including a description of the training program, the categories of employees trained, the frequency of training and the basic topics covered in the training in a written or electronic form. This had the potential to affect all residents and their families. Findings include: During a review of the facility's Alzheimer's training program, there was no information or documentation that indicated the consumers (resident families) were provided a description of Alzheimer's training program, categories of employees trained, frequency of training and the basic topics covered. During an interview on 7/21/15, at 4:07 p.m., the social worker stated, dementia training was completed through educare. She stated she not sure how resident families received this information. The director of nursing (DON) stated, no family education was provided regarding Alzheimers' training, and she was unaware that it was required. SUGGESTED METHOD OF CORRECTION: The DON or designee could add information regarding staff training to the resident admission packet so consumers were aware of this information. The DON or designee could educate staff about this requirement and conduct audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302	Corrected 8/18/15	

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2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care for timely repositioning and toileting assistance for 1 of 1 residents (R50) with urinary incontinence, and at risk for pressure ulcer development. Findings include: R50's diagnoses, as identified on the care plan (CP), reviewed 6/6/2015, included hemiplegia affecting dominant side, dementia, and aphasia due to cerebrovascular disease. The quarterly Minimum Data Set (MDS), dated 5/27/2015, indicated R50 had severely impaired cognition, and was unable to walk. The MDS also identified R50 required extensive, physical assistance for activities of daily living (ADLs), including two-person assist with bed mobility, transfers, toileting, and personal hygiene. R50's care plan (CP) identified the potential for alteration in skin integrity, and also R50's alteration in elimination/toileting. The CP directed staff to follow the mobility plan of care, and assist R50 "to turn and reposition every 2 hours and PRN" [as needed]. Additionally, the CP directed staff to assist R50 "to check and change every 2	2 565	corrected 8/20/15	8/20/15

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2 565	Continued From page 5 hours and PRN" [as needed]. During continuous observation on 7/23/2015 from 7:55 a.m. to 11:12 a.m. (3 hours and 7 minutes) R50 was observed to be dressed and seated upright in her wheel chair. At 7:55 a.m., R50 was seated in her wheel chair in the living area across from the north unit nursing station and watching a news program on TV. At 8:33 a.m., R50 was wheeled into the dining room and assisted with breakfast, finishing at 9:36 a.m. Following the meal, and still seated in the wheel chair, R50 was moved from the table where food was served to the activity area in the same room. R50 participated in the morning activity, and stayed in the activity area until just after 10:00 a.m., when a staff member wheeled her into the main entryway of the facility. R50 remained there, still seated in her wheel chair, until 10:19 a.m., when a staff member pushed R50 outside of the building, joining other residents to get fresh air. At 10:37 a.m., R50 was returned into the building near the aviary, and was approached by nursing assistant (NA)-F, who after greeting R50, took her vital signs. More than 2 1/2 hours had elapsed since R50 was last toileted or repositioned. R50 remained seated in her wheel chair near the aviary until 11:12 a.m., when NA-F assisted her back to her room. In her room, NA-F and registered nurse (RN)-B, using the mechanical lift, assisted R50 into her bed. R50 was incontinent of urine, and NA-F provided perineal care. RN-B assessed R50's skin, which was pink in color, free of any unusual warmth or swelling, there were no reddened areas, and her skin was fully intact. RN-B also said R50 was incontinent of urine. R50 was not toileted or repositioned from 7:55 a.m. to 11:12 a.m., a total of 3 hours and 7 minutes.	2 565		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 6 During an interview on 7/23/2015 at 11:16 a.m., nursing assistant (NA)-F stated R50 was last repositioned when she was put in her wheel chair "at about quarter to eight." NA-F then stated R50 was on an "every two hour repo [repositioning] schedule," and that R50 should also be checked for "urinary incontinence." NA-F said R50 "Was definitely ready to be repositioned." In an interview on 7/23/2015 at 4:00 p.m. registered nurse (RN)-A said she "trusted the work group on the floor to get toileting and repositioning completed," but what happened today, "I'll say was a fluke." RN-A also stated, "I'll be honest, [R50] should have been turned." During an interview on 7/27/2015 at 1:19 p.m., the director of nursing (DON) said resident interventions were care planned, and the facility takes "very seriously, residents' needs for timely assistance." A facility policy regarding the implementation of care plans was requested, but none provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and / or designee could review the importance of implementing all residents' plan of cares, to assure resident needs are being met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position	2 905		8/20/15

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	00374	A. BUILDING: _____ B. WING _____	07/27/2015

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2 905	Continued From page 7 must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning for 1 of 2 residents (R50) reviewed in the sample identified at risk for development of pressure ulcers. Findings include: R50's diagnoses, as identified on the care plan (CP), reviewed 6/6/2015, included hemiplegia affecting dominant side, dementia, and aphasia due to cerebrovascular disease. The quarterly Minimum Data Set (MDS), dated 5/27/2015, indicated R50 had severely impaired cognition, and was unable to walk. The MDS also identified R50 required extensive, physical assistance for activities of daily living (ADLs), including two-person assist with bed mobility, transfers, toileting, and personal hygiene. A Braden Pressure Sore Risk Assessment, dated 5/26/2015, indicated R50 was at moderate risk for development of pressure sores. A comprehensive skin assessment summary, dated 5/26/2015, identified R50 required extensive to total assist with ADLs, that she was unable to walk, and was on a turn-and-reposition schedule every 2 hours. The care area assessment (CAA) for pressure ulcers, dated 2/25/2015, identified additional pressure ulcer risk factors for R50 including immobility, incontinence, cognitive loss	2 905	corrected 8/20/15	

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2 905	Continued From page 8 and functional limitation in range of motion. R50's CP identified the potential for alteration in skin integrity. The CP directed staff to follow the mobility plan of care, and assist R50 "to turn and reposition every 2 hours and PRN" [as needed]. The nursing assistant care sheet "North" unit, undated, directed for R50: T & R q 2 hrs [turn and reposition every 2 hours]. During continuous observation on 7/23/2015 from 7:55 a.m. to 11:12 a.m. (3 hours and 7 minutes) R50 was observed to be dressed and seated upright in her wheel chair, with her right hand and wrist fitted with a splint device, and her right arm was supported and strapped into the arm rest. At 7:55 a.m., R50 was seated in her wheel chair in the living area across from the north unit nursing station and watching a news program on TV. At 8:33 a.m., R50 was wheeled into the dining room and assisted with breakfast, finishing at 9:36 a.m. Following the meal, and still seated in the wheel chair, R50 was moved from the table where food was served to the activity area in the same room. R50 participated in the morning activity, and stayed in the activity area until just after 10 a.m., when a staff member wheeled her into the main entryway of the facility. R50 remained there, still seated in her wheel chair, until 10:19 a.m., when a staff member pushed R50 outside of the building, joining other residents to get fresh air. At 10:37 a.m., R50 was returned into the building near the aviary, and approached by nursing assistant (NA)-F, who after greeting R50, took her vital signs. More than 2 1/2 hours had elapsed since the initial observation, and still R50 was not off loaded, or repositioned out of her wheel chair. R50 remained seated in her wheel chair near the aviary until 11:12 a.m., when NA-F assisted her back to her room. In her room,	2 905		

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2 905	Continued From page 9	2 905		

NA-F and registered nurse (RN)-B, using the mechanical lift, assisted R50 into her bed. R50 was incontinent of urine, and NA-F provided cleansing cares for her. In the presence of the surveyor, RN-B inspected and assessed R50's skin. R50's skin was normal pink in color, free of any unusual warmth or swelling, there were no reddened areas, and her skin was fully intact. RN-B also said R50 was incontinent of urine. R50 had not been repositioned from 7:55 a.m. to 11:12 a.m., a total of 3 hours and 7 minutes.

During an interview on 7/23/2015 at 11:16 a.m., nursing assistant (NA)-F stated R50 was last repositioned when she was put in her wheel chair "at about quarter to eight." NA-F then stated R50 was on an "every two hour repo [repositioning] schedule," and R50, "Was definitely ready to be repositioned."

A review of nursing and physician long-term care progress notes from 3/26/2015 to 7/14/2015, indicated R50 did not have, nor was being treated for a current pressure ulcer. During this time, R50 did not develop a pressure ulcer.

In an interview on 7/23/2015 at 4:00 p.m. registered nurse (RN)-A stated she would consider any resident "who had a stroke to be at risk for pressure sores." RN-A also said she would "look at everything" to determine if a resident was at risk to develop a pressure ulcer. RN stated R50 scored "a 13 on the Braden" (a measure for predicting pressure ulcer risk), but that also R50 "had immobility, incontinence, and other risk factors" and was "at risk for pressure." RN-A said she trusted the work group on the floor to get toileting and repositioning completed, but what happened today, "I'll say was a fluke." RN-A also stated, "I'll be honest, she should have been

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2 905	Continued From page 10 turned." During an interview on 7/27/2015 at 1:19 p.m., the director of nursing (DON) said the nurse manager had already taken steps to avoid issues when a resident is on a schedule to be turned and checked for incontinence. The DON said in this instance, "[R50] should not go right from breakfast into other activities, that is too long." The DON said resident interventions were care planned, and the facility takes "very seriously, residents' needs for timely assistance." A facility policy, Treatment and Prevention of Skin Breakdown and Ulcers, reviewed 3/14, indicated "It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity..." and "implement preventive measures..." Further, the policy directed, to "establish and record an individualized turning and repositioning schedule if the resident is immobile." SUGGESTED METHOD OF CORRECTION: The Director of Nursing and / designee could review with care staff residents requiring repositioning for pressure ulcer preventing and healing, and monitor for compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 905		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the	2 910		8/20/15

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2 910	Continued From page 11 unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely toileting assistance for 1 or 1 residents (R50) who had urinary incontinence. Findings include: R50's diagnoses, as identified on the care plan (CP), reviewed 6/6/2015, included hemiplegia affecting dominant side, dementia, and aphasia due to cerebrovascular disease. The quarterly Minimum Data Set (MDS), dated 5/27/2015, indicated R50 had severely impaired cognition, and was unable to walk. The MDS also identified R50 required extensive, physical assistance for activities of daily living (ADLs), including two-person assist with bed mobility, transfers, toileting, and personal hygiene. A bowel and bladder assessment, dated 2/25/2015, indicated R50 was incontinent of bowel and bladder, and also was not safe to use a commode or toilet due to poor trunk control. Further, the assessment indicated R50 would "be checked for incontinence	2 910	corrected 8/20/15	

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2 910	Continued From page 12 q 2hr [every 2 hours] and peri care given after each incontinence episode." The care area assessment (CAA) for urinary incontinence, dated 3/11/2015, indicated R50 had dementia, and past history of cardio-vascular accident (stroke), with right-sided hemiplegia. The CAA also indicated R50 was not a candidate for retraining. R50's CP identified alteration in elimination/toileting, that she was incontinent of bowel and bladder, and also that R50 was not using the bathroom due to safety. The CP directed staff to assist R50 "to check and change every 2 hours and PRN" [as needed]. The nursing assistant care sheet "North" unit, undated, also directed for R50: Check and change q 2hrs and PRN [every 2 hours and as needed]. During continuous observation on 7/23/2015 from 7:55 a.m. to 11:12 a.m. (3 hours and 7 minutes) R50 was observed to be dressed and seated upright in her wheel chair, with her right hand and wrist fitted with a splint device, and her right arm was supported and strapped into the arm rest. At 7:55 a.m., R50 was seated in her wheel chair in the living area across from the north unit nursing station and watching a news program on TV. At 8:33 a.m., R50 was wheeled into the dining room and assisted with breakfast, finishing at 9:36 a.m. Following the meal, and still seated in the wheel chair, R50 was moved from the table where food was served to the activity area in the same room. R50 participated in the morning activity, and stayed in the activity area until just after 10 a.m., when a staff member wheeled her into the main entryway of the facility. R50 remained there, still seated in her wheel chair, until 10:19 a.m., when a staff member pushed R50 outside of the building, joining other residents to get fresh air.	2 910		

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2 910	Continued From page 13 At 10:37 a.m., R50 was returned into the building near the aviary, and approached by nursing assistant (NA)-F, who after greeting R50, took her vital signs. More than 2 1/2 hours had elapsed since the initial observation, and still R50 was not off loaded, or repositioned out of her wheel chair. R50 remained seated in her wheel chair near the aviary until 11:12 a.m., when NA-F assisted her back to her room. In her room, NA-F and registered nurse (RN)-B, using the mechanical lift, assisted R50 into her bed. R50 was incontinent of urine, and NA-F provided cleansing cares for her. In the presence of the surveyor, RN-B inspected and assessed R50's skin, and also said R50 was incontinent of urine. R50 was not assisted for toileting from 7:55 a.m. to 11:12 a.m., a total of 3 hours and 7 minutes. During an interview on 7/23/2015 at 11:16 a.m., nursing assistant (NA)-F stated R50 was last repositioned when she was put in her wheel chair "at about quarter to eight." NA-F then stated R50 was on an "every two hour repo [repositioning] schedule," and that R50 should also be checked for "urinary incontinence." In an interview on 7/23/2015 at 4:00 p.m. registered nurse (RN)-A stated she would consider resident "who had a stroke to be at risk for pressure sores." RN stated R50 scored "a 13 on the Braden" (a measure for predicting pressure ulcer risk), but that also R50 "had immobility, incontinence, and other risk factors" and was "at risk for pressure." RN-A said she trusted the work group on the floor to get toileting be completed, but what happened today, "I'll say was a fluke." During an interview on 7/27/2015 at 1:19 p.m., the director of nursing (DON) said the nurse	2 910		

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2 910	Continued From page 14 manager had already taken steps to avoid issues when a resident is on a schedule to be turned and checked for incontinence. The DON said in this instance, "[R50] should not go right from breakfast into other activities, that is too long." The DON said resident interventions were care planned, and the facility takes "very seriously, residents' needs for timely assistance." A facility policy, Bowel and bladder Program Policy, revised 3/14, indicated as its purpose to "Maintain resident's optimal bowel and bladder continence and maintain skin integrity The policy indicated individual care plan will address "Times to toilet based on individual schedule and/or checking for incontinence." SUGGESTED METHOD OF CORRECTION: The Director of Nursing and / designee could review with care staff residents requiring assistance with toileting, and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by:	21565		8/13/15

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21565	Continued From page 15 Based on observation, interview and document review, the facility failed to ensure safe self-administration of medications (SAM) for 1 of 1 residents (R63) observed for self-administration of a nebulizer treatment. Findings include: During observation on 7/20/15, at 7:28 p.m. R63 was observed alone in her room with a nebulizer (a drug delivery device used to administer medications in the form of a mist inhaled into the lungs) running, with a face mask. The trained medication aide (TMA)-A who had administered the medicaiton was on the opposite side of the dining room passing medications and assisting other residents in their rooms. R63 remove the mask off her nose and mouth and placed the mask on her chest with the elastic strap still around the back of her neck. The TMA-A walked past R63's room while R63 had the mask on her chest and into the room next to R63 twice. TMA-A made no attempted to check, or reapply the mask to R63's nose and mouth for installation of the medication. At 7:44 p.m. TMA-A entered R63's room turned off the nebulizer and removed the mask from R63's chest. R63's diagnoses included dementia with behavioral disturbances, depression, anxiety, chronic obstructive pulmonary disease (COPD) and congestive heart failure. A cognition care plan dated 6/2/15, indicated R63 was disorientated to time and place and had moderately impaired cognition. The Physician's Orders and the Medication Administration Record (MAR) for 7/15, directed Duoneb to be administered four times a day. A hand written note on the MAR indicated R63 did	21565	corrected 8/13/15	

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21565	Continued From page 16 not like the nebulizer mask and to hold the mask in front of her face and let her breathe in that way. A Self Administration of Medication Assessment effective 7/21/15, indicated R63 was not cognitively able to participate in a SAM. During interview on 7/20/15, at 7:50 p.m. TMA-A stated she did not know if R63 could be left alone with the nebulizer. She usually does not leave residents alone with their nebulizer but because it had been so hectic and busy she left R63 alone. On 7/23/15, at 11:20 a.m. registered nurse (RN)-A stated R63 was assessed to not to be left alone to SAM the nebulizer. In the past she would not even allow the mask but now will allow staff to hold the mask in front of her. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and/or designee could review the facility's policy for assessment of residents for the ability for self administration of medications, with the facility staff responsible. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21565		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written	21685		8/18/15

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21685	Continued From page 17 routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure exhaust fan duct work, lights above grill and screen in the kitchen were clean of dust and debris. This had potential to affect all residents, staff and visitors who consumed food from the kitchen. Findings include: During the initial tour of the facility kitchen with registered dietician (RD) on 7/20/15, at 1:15 p.m.; six metal caged lights above the grill where the food is cooked, were covered with 1/4 inch visible thick dust and debris from the light fixtures. In addition there was a 12 inch long by 6 inch window screen above the kitchen sink was completely covered in a black dust and debris. An additional tour was completed on 7/21/15, at 7:30 a.m. the lights and screen were still observed to be covered with visible dust and debris. During interview 7/21/15, at 8:15 a.m. dietary manager (DM) stated the lights were covered in dust along with the screen and the maintenance department was in charge of cleaning those. The DM stated the maintenance has a staff of 5 and 3 of them are on light duty so things just are not getting done. During interview 7/21/15, at 8:30 a.m. the maintenance manager (MM)-A stated they have a contracted service that cleans the overhead hood vent two times a year. The maintenance	21685	corrected areas cited were cleaned on 7/21/15	

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21685	Continued From page 18 director did inspect the lights and the screen and stated "That doesn't cut it" and expressed it is still the expectation to complete needed tasks. Review of the facility contracted cleaning service document form Fire Protection Equipment Co. After Service Follow Up Report dated 9/22/14, indicated the kitchen exhaust system hood was cleaned but not to code due to them being inaccessible. The recommendations indicated to "replacing box-style fan with upblast style to better access duct work." The company was out again on 3/2/15 and the Fire Protection Equipment Co. After Service Follow Up Report recommended "replacing box-style down blast fan with upblast fan to access fan and duct work. Replace damaged filters." During interview 7/22/15, at 2:00 p.m. the MM-A stated the "fan blows down and then diverts the air up to create a vacuum up and out of the roof". The MM then stated the fans should be cleaned, but that is how this style exhaust fan works and it is grandfathered until we remodel the kitchen at some uncertain time. During phone interview 7/22/15, at 2:15 p.m. with representative from the Fire Protection Equipment Co. stated the fan and ducts are inaccessible because they were unable to see down to the bare metal. The system was very old, which was probably manufactured in 1960's or 70's, and recommended a new unit. The facilities Nutritional Services Cleaning Procedure Equipment Hood policy undated indicated 1. the inside and outside of the hood will be cleaned once per month 2. clean the inside and outside of the hood	21685		

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MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

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21685	Continued From page 19 3. clean the light fixtures within the hood. Remove the light fixtures and clean with soap 4. use a brush or cloth as needed to remove grease and/or dust 5. wash hood with soap and water 7. the interior section of the hood that extends to the roof is cleansed semi annually by a commercial hood-cleaning operator. SUGGESTED METHOD OF CORRECTION: The Administrator and / or designee could review the cleaning schedule within food service and determine the frequency that high areas should be cleaned. TIME PERIOD FOR CORRECTION: Seven (7) days.	21685		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified rising and morning routines for 2 of 8 residents (R50 and R12),who required extensive staff assistance to complete activities of daily living (ADL's).	21805	corrected 8/14/15	8/14/15

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21805	Continued From page 20	21805		

R50's diagnoses, as identified on the care plan (CP), reviewed 6/6/2015, included hemiplegia, dementia, and aphasia. The quarterly Minimum Data Set (MDS), dated 5/27/2015, indicated R50 had severely impaired cognition, required extensive, physical assistance for ADL's, including two-person assist with bed mobility, transfers, toileting, dressing and personal hygiene.

During observation on 7/22/2015 at 7:11 a.m., R50 was lying on her back, in her bed, with her left hand positioned on top of her chest. R50's blanket was at the foot of the bed, pulled onto the resident, exposing R50's left leg, and one could see she already had pants on as she lied in bed. R50 remained in bed until 8:41, when NA-F and NA-G assisted her with morning cares. R50 was already dressed, with pants, socks and shirt, when NA-F removed R50's covers and checked for incontinence, NA-F and NA-G assisted R50 into her wheel chair with use of a mechanical lift. NA-F then brushed her hair, and NA-G assisted in placing R50's hand splint and arm into the wheel chair armrest and R50 was up for the day.

During an interview on 7/22/2015 at 8:38 a.m., NA-G said R50 was already dressed this morning, and we "just needed to get up, out of bed." NA-G said R50 needed "total assistance" dressing, and R50 was not able to verbalize her needs to staff.

In an interview on 7/22/2015 at 9:18 a.m., NA-F acknowledged R50 was dressed this morning when she assisted R50 to get up for the day. NA-F did not know who worked with R50, but said "someone on nights [the night shift] got her dressed," and that was typical for R50's routine. NA-F also said R50 would not be dressed early

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21805	Continued From page 21 on Tuesdays, "because she gets a bath on that day." During an interview on 7/24/2015 at 6:00 a.m., NA-H stated she works on the overnight shift, and routinely got R50 "cleaned up and dressed," but not removed from bed, "the day shift would do that." NA-H stated she does not get R50 dressed on her scheduled bath days. She has a list of residents whom she helped get cleaned and dressed, prior to the end of the night shift. NA-H said "I just need to make sure they are dressed and ready to go. I get them dressed and then put them back to bed; it helps out the morning shift." NA-H said if there was a resident that did not want to get up, she was instructed "to get someone else up." NA-H did add that some of the residents she assisted "liked to get up early," and there were some who simply "were up all night anyway." During an interview on 7/24/2015 at 1:06 p.m., family member (FM)-A said he was unaware staff were getting R50 dressed, then having her stay in bed. FM-A said that depending on the night, R50 was often awake late, or was "up at 3:00 a.m. and restless, and they [staff] will get her up." FM-A than stated, "I would think if [R50] got dressed, she'd be getting out, and up to breakfast for the day." In an interview on 7/24/2015 at 1:17 p.m., the director of nursing (DON) stated the night shift try "to help the day shift staff." The DON said "If someone was trying to get up, then get them up, and keep [the resident] from getting out of bed and possibly fall." In the same interview, the social worker (SW) said getting a resident up during the night was "not just a decision for the aide. We should look into this some more."	21805		

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21805	Continued From page 22 R12's quarterly minimum data set (MDS), dated 5/18/15, indicated she was severely, cognitively impaired and required extensive assist for transfers, dressing and grooming. The care plan (CP), dated 8/28/13, directed staff to give R12 opportunities to make daily preferences choices, including clothing, bed time and bathing. The CP also indicated R12 had an alteration in sleep, related to insomnia, with a goal of at least six hours of sleep at night. The CP did not address a morning routine preference of when R12 wanted to get up. During observation on 7/22/15 at 7:00 a.m., R12 was noted fully dressed and seated in her wheel chair. R12 was positioned in front of the television in the common area on the east wing, asleep in her wheelchair. R12 repeatedly made jerking movements as she dozed. R12 remained in chair until 8:15 a.m., (75 minutes) when staff approached, and awakened her. The staff asked R12 if if she wanted to go back to bed, or eat breakfast. R12 replied "I don't care." During an interview on 7/24/15, at 5:59 a.m., NA-E stated she was instructed to get four residents up, washed and dressed when working the over night shift. NA-E stated if a resident had shower, there was another one assigned to get up in their place. NA-E stated she will usually "get the residents up, washed, dressed and put them back to bed." During an interview on 7/24/15 12:24 p.m., licensed practical nurse (LPN)-C stated, " usually the over night shift is getting up the early risers, she stated they are not getting up anyone that would normally sleep in. LPN-C further stated,	21805		

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21805	Continued From page 23 "Some of the Hoyers [residents who require use of a mechanical lift to transfer] get washed, dressed and put back in bed, I don't have any idea why they would do that." During an interview on 7/24/15, at 1:16 p.m., the director of nursing (DON) stated, there are many people getting up and dressed and put back to bed on the night shift. She stated, The nurses and care coordinators schedule them to help the day shift. The DON further stated, "the people on this list are usually up or crawling out of bed," we like the night shift to help day shift "get a jump on the day." She further stated, "I'm sure we are not the only nursing home in the world that does that." The intent is to help day shift out and prevent falls. The DON stated she was not sure if the rationale for waking a resident on night shift to get them washed and dressed is on the care plan or not. During an interview on 7/24/15, at 2:07 p.m., registered nurse (RN)-C stated, We schedule residents for the night shift to get up, washed and dressed. She stated, We usually look at people who are trying to get up but if there aren't enough people who want to get up, we will pick people who are a "Hoyer lift." The aides will wash and dress them in bed. RN- C stated, "If someone prefers to get up early it is not care planned." She further stated, there is no one currently on the East unit that is care planned to get up early due to fall risk. RN-C stated, The rationale for night shift getting resident's washed and dressed is due to the workload in the morning. Review of the facility's undated East night group sheet directed night shift to complete morning cares, oral cares, dressing, making bed and cleaning up room for five residents on the unit,	21805		

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21805	Continued From page 24 including R12. A review of the facility policy, Rights and Responsibilities of Patients/Residents, dated 4/15, indicated the facility "must, with courtesy, promote care for [residents] in a manner that maintains and enhances dignity and respect in full recognition of [a resident's] individuality." SUGGESTED METHOD OF CORRECTION: The Administrator and/or designee could inservice facility staff in regards to provision of care in a dignified manner. They could create an auditing system to ensure residents are being treated with dignity. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21805		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined	21990		8/21/15

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21990	Continued From page 25 in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure all allegations of abuse, neglect, mistreatment and injuries of unknown were immediately reported to the adminstrator and state agency, were thoroughly investigated, and residents were protected during their investigations for 8 of 15 residents' (R47, R12, R22, R39, R11, R66, R44 and R8) allegations reviewed. The facility failed to conduct reference checks for 4 of 5 newly hired employees (NA-A, NA-B, DA-A and RN-B). Findings include: Investigation and Protection During interview 7/23/15, at 5:09 p.m. with social worker (SW) stated that nursing assistant (NA)-C has been implicated in four incident reports from January 2015 to July 2015 as the potential alleged perpetrator (AP). Review of facility Incident and Investigation reports indicated the following: R47's quarterly Minimum Data Set (MDS) dated 2/17/15, indicated she was moderately cognitively intact and needed extensive assistance in ADLs. R47's care plan dated 2/26/15, indicated she had dementia and needs assist with dressing, grooming and bathing. The care plan further indicated she had slight alteration in cognition related to dementia and that resident will continue to be oriented to person, place and time.	21990	corrected8/21/15	

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21990	Continued From page 26 Mille Lacs Nursing Home Progress Notes dated 1/24/15, at 3:49 a.m. indicated: "This nurse [LPN-D] was in a res. room, 5 rooms away from where the incident happened, but heard a distinct smack. Followed by a woman's out cry. This nurse then got a call on the walkie [walkie-talkie] from the aide. The aide stated (in her words) On 2 a.m. rounds, I went to check resident in room 45-1 and woke up resident in 45 -2 [R47] in the process. I told [R47] the time and said she should lay back down and try and get some sleep until coffee time. [R47] said "No, I want to sit up I'm waiting." NA-C said "No lets lay down" and NA-C went to pick up [R47's] feet to bring them in bed and [R47] swung and hit me in the head, fairly hard. I [NA-C] yelled out "ow" and NA-C said "why did you hit me, R47 said "I didn't, you hit me you liar" then [NA-C] walked out and walkie the nurse...." This nurse [LPN-D] asked the res. why she hit the aide. Res. [R47] stated that the aide hit her." An Incident Report submitted to the state agency on 1/28/15, indicated that R47 had a conflict with a nursing assistant on 1/24/15. Following a review of the related progress notes, and supervisory staff, it was originally determined R47's incident was due to her dementia. Further study revealed that R47 allegedly struck a nursing assistant, but resident [R47] also alleged the nursing assistant struck her. The report indicated a further investigation needed to be completed. A follow-up Investigative Report was submitted to the state agency on 2/2/15. The report indicated the SW met with the resident R47 on the a.m. of 1/28/15 and 1/30/15 and resident was unable to recall any incidents of concerns. The SW was unable to speak with NA-C until 2/2/15 (7 days	21990		

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21990	Continued From page 27 after the SW learned of the situation) in part due to her work schedule not coinciding with the SW. SW spoke with NA-C by phone on 2/2/15, at 10:45 p.m. NA-C acknowledged the incident happened as described by LPN-D's note. NA-C stated she had not struck R47 in any way, but had tried to lift R47's legs to help her lay down. The investigative report indicated the AP was NA-C. This report also included that NA-C had been implicated in a previous submitted report. During interview 7/23/15, at 5:10 p.m., the SW stated the resident was unable to recall if the incident had happened, and said R47 had dementia. The SW said NA-C was not suspended during her investigation because it could "not be proved" that NA-C abused R47, and R47 continued to be on the work schedule. The SW said NA-C was counseled on how to provide cares for R47, and was asked for ideas from NA-C on how to keep R47 safe. Review of the facility's MLHS-LTC NA/R Schedule indicated NA-C was not suspended pending the investigation of the incident dated 1/28/15 and NA-C was scheduled to work 1/28/15 and 1/29/15, while the investigation was in progress. The investigation of this incident lacked timely interviewing of the NA-C. This incident occurred on 1/24/15 but was not reported to the SA until 1/27/15. The investigation did not determine if the R47 was actually abused. The facility did not suspend NA-C or take action to protect residents, during the investigation. There was no indication that a thorough investigation was completed for R47.	21990		

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21990	Continued From page 28	21990		

R47 had another facility Social Service Incident Referral Form (SSIRF), signed by RN-C indicated R47 was involved in an incident on "3/2/15 early a.m., of possible abuse or resident aggression." The SSIRF indicated: RN-C noted PCC notes (electronic progress notes) by LPN-B questioning verbal statements and other behaviors by resident [R47]; possible indication of maltreatment but just a likely symptoms of resident's dementia." The SSIRF further indicated the incident was discussed with Investigative Team on 3/3/15 at 8:30 a.m., and reported submitted to the state agency on 3/3/2015 at 12:30 p.m. The report also indicated NA-C was a person with credible knowledge of the situation.

An initial Incident Report was submitted to the state agency on 3/3/15 regarding possible abuse of R47 on 3/2/15. The report referenced "two progress notes from NOC (night) shift early that a.m. of 3/2 that suggests either some behavioral concerns/dementia symptoms by resident [R47] at work or possible maltreatment of resident by staff." The report indicated uncertainty by staff on whether this was maltreatment, and "SW decided to go ahead and submit the allegation to [state agency]...."

A nursing progress note, dated 3/2/215 at 4:03 a.m., written by LPN-B, indicated [R47] was "kicking at staff" and [R47] told staff "she was going to report 'her' to the nurse.." The note also indicated R47 told staff "you go around hitting everyone I heard.." On 3/2/15 at 6:03 a.m., a second progress noted indicated staff went to wipe dry blood off [R47's] lip, and [R47] hit staff. The note continued, that after R47 hit staff, R47 stated "I am going to report you for hitting me."

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21990	Continued From page 29 Facility documentation did not indicate any action was taken to protect R47 and other residents during this investigation of potential abuse. Documentation of the investigation of this incident did not include determination the cause of R47's bloody lip, and there was no evidence of interview with the nursing assistant who provided cares for R47. The SSRIF also indicated there was no immediate reporting of this incident to the state agency or administrator. A final, Investigative Report was submitted to the state agency on 3/06/15 regarding the incident. The report indicated on 3/2/15 the "resident was interviewed by RN Care Coordinator (RN- A) and this SW. Resident denied remembering anything happening this past weekend during the daytime or the nighttime that upset her in any way.....She denied that anyone hits her or has been mean to her or that she has hit anyone else." The report also indicated "SW communicated with [LPN-B] about progress notes from 3/2/15 during night shift, "indicating the NAR was situating resident in the EZ lift (mechanical lift) to help her to the bathroom per resident's request and the NAR noticed resident's lip had been bleeding apparently cracked from being chapped with dry, winter air. [NA-C] told [R47] she was going wipe the dried blood off, but R47 struck out at NA, causing NA's glasses to dismount from her face." The report indicated NA-C re-approached later and assisted [R47] without incident. Later the same night, the NA was doing rounds and attempted to lift R47's feet back in bed, and resident kicked at NA-C. The report then referenced the allegations made by R47, that she was slapped. The report did not confirm a perpetrator in this incident. The report indicated R47's care plan was reviewed, and suggestions were made on how to approach R47 during	21990		

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21990	Continued From page 30	21990		

cares. The report also indicated LPN-B was coached by the SW and DON on more thorough progress note charting, and further, that staff have been reminded to submit timely incident reports. The report included: "Something is just not resting well with this, and although there is no maltreatment of residents 'substantiated' in this particular incident, SW will continue to keep eyes and ears open for patterns and/or trends in conduct, etc."

Review of the facility's MLHS-LTC NA/R Schedule from February 23, 2015 to March 8, 2015, indicated NA-C was assigned to work 3/2/15 (the night of the alleged incident) and also worked on 3/3/15.

During interview 7/23/15, at 5:30 p.m. the SW stated, in review of this incident, she had "concerns with NA-C" but again could not prove she had really done anything wrong. The facility felt they could not substantiate the allegations against NA-C, and therefore did not warrant a "suspension or discipline" during the investigation. There was no indication that a thorough investigation was completed for R47.

R12's quarterly MDS dated 4/27/15 indicated she was moderately cognitively intact and needed extensive assist with dressing, bathing and grooming. R12's care plan dated 1/31/15, indicated she had potential for abuse from others related to cognitive impairment and limited mobility.

An initial Incident Report submitted to the state agency on 2/18/15, indicated that on 2/18/15, R12 was allegedly slapped, on her cheek, by a staff person who was attempting to administer

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medicine. The AP on the Incident Report was listed as unknown.

A final Investigative Report was submitted to the state agency on 2/23/15, regarding the incident. The report indicated R12 had made numerous allegations, but the only allegation that could be "tracked," was the one about someone slapping [R12] during the administration of Milk of Magnesia (MOM) that morning. Firstly, the report indicated the SW and DON proceeded to seek more information about who would have administered the MOM that morning. Per schedule, LPN-B and NA-C were the persons on duty. At 10:45 p.m. on 2/19/15, the DON and SW met with NA-C, who freely admitted having given MOM to R12 under direction of LPN-B. NA-C said "[R12] didn't want the MOM, and [R12] took the cup and threw the MOM all over." [NA-C] tried to clean it up off the bedding, resident's clothing and her face, using wet wipes." The report indicated NA-C denied slapping R12 in any way, but acknowledged wiping R12's face off with the wet ones. The report indicated, "It is possible this was perceived by [R12] as a slap." The SW asked NA-C to go to resident's room to see if resident could/would or would not identify her as the lady who slapped her, and NA-C agreed to do so. [R12] was sleeping soundly, however, so decided not awaken her. The report indicated "[NA-C's] willingness to go, however, leads SW to believe she [NA-C] is being truthful about not slapping resident." The report then indicated the DON spoke to LPN-B by phone on 2/23/15 at 3:20 p.m. LPN-C admitted asking NA-C to give MOM to R12 due to LPN being occupied elsewhere LPN-C also acknowledged that NA-C did report [R12's] claim of being slapped by a "blonde lady." The report then indicated staff have been alerted to have two

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persons present during cares with this resident and NA-C was instructed not to enter room without a colleague present.

During interview on 7/23/15, at 5:20 p.m. the SW stated she did not suspend NA-C since they could not prove NA-C slapped R12. The SW acknowledged NA-C had been involved in multiple incidents, and had "suspicions" with [NA-C], but did not feel "there was a reason to suspend" or provide disciplinary action to her during this investigation.

The investigation of this incident by the facility did not determine if R12 was slapped, nor was there follow up to have R12 positively identify the nursing assistant who provided cares. Although NA-C was instructed not to enter R12's room without a colleague present, the documentation offered no indication protections were put in place for other residents who were assisted by NA-C during this investigation of this incident, regardless of its outcome.

R22's admission MDS dated 4/24/15, indicated she had depression and a cerebral vascular accident (CVA), was moderately cognitively impaired and needed limited assist with transfers and extensive assist with toileting. R22's care plan dated 5/3/15, indicated she needed assist with toileting and transfers, had history of depression and sadness/isolating self. R22's care plan further indicated she had potential for abuse from others related to her general weakness, aches and pains. The care plan goal indicated "resident will remain safe and have needs met in a safe environment."

During observation on 7/20/15, at 5:54 p.m. R22

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lifted her pant leg and displayed a bruise on her right shin measuring approximately 8 cm (centimeters) x 2 cm.. R22's bruise was black, fading to dark purple in color, with no apparent swelling

In an interview 7/20/15, at 5:54 p.m. R22 stated that she had been treated "roughly by the staff" and there is a staff member who works the night shift that is rough with her. R22 went on to state this staff member had "grabbed her arm when transferring" which caused a large bruise and also stated she had also hit her leg into the metal bar along the bottom of her bed.

The facility submitted an Incident Report to the state agency on 6/27/15, regarding an incident of alleged mistreatment and physical abuse of R22. The report also identified a bruise on R22's top right hand, measuring 5.5 cm x 5 cm, circular in shape; and a second bruise on R22's lower right shin 2.5 cm x 2.5 cm, circular in shape. The report was submitted by RN-D, and indicated that the initial reporter, NA-A, was also the alleged perpetrator in this incident. The report indicated, nursing assistant (NA)-C reported at 5:15 a.m., she had toileted R22, After being toileted, R22 told [NA-C] she was not coming back tonight,and that "some girl hurt her." NA-C asked who, and she [R22] stated she doesn't know who. The report then indicated that registered nurse (RN)-A, followed up with R22 in the morning and asked her to tell her what happened: "Resident reported she is not staying here again tonight and is not going to be treated like this anymore." R22 explained that staff was mad at her during the night for getting up to use the bathroom so many times, and that a "girl grabbed me and threw me into bed." R22 pointed out her hand hurt, and said "this is where she grabbed me," noted a

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bruise on top of right hand measures 5.5 cm (centimeters) x 5 cm circular is shape. R22 also reported when she threw me into bed, "I hit my leg on something metal;" a bruise noted on right outer lower shin measures 2.5 cm x 2.5 cm circular in shape. R22 could not recall who the girl was, nor her name. R22 thought it was around 0400. The report further indicated NA-C was the nursing assistant working on that wing during the night, and LPN-A was the nurse in charge. No other injuries noted, resident was reassured she will remain safe here, NA-C will be removed from working with resident at this time.

An additional Incident Report was submitted to the state agency on 7/1/15, which identified an injury of unknown source on R22's right forearm 8 x 5 cm, reddish purple in color, and oval in shape. The date of incident occurrence was unknown. The report indicated R22 said, "It happened a few days ago."

An Investigative Report was submitted to the state agency on 07/02/15, which combined the two submitted incident reports. The report indicated the DON and social worker SW "have tried to investigate this issue thoroughly and have been unable to substantiate who the alleged perpetrator [AP] is for certain, but have reached a conclusion there is reasonable suspicion a crime may have occurred in the form of assault, and are hence submitting a report also to law enforcement, in accordance with Elder Justice Act." Further, "The details of our internal investigation to the limits of our ability are being submitted to OHFC [Office of Health Facility Complaints] the state agency." The Investigative Report further indicated on 7/1/15, the DON and SW met with the AP, (NA-C) who stated R22 had requested to use the toilet 6-8 times that night

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(6/27/15). The report then indicated [SW and DON] "discussed with the AP the number of previous incidences involving this NAR, which can raise red flags re [regarding] her credibility, and she became somewhat defensive, face reddening and voice tightening, saying 'it's because I report things and others don't, so I end up getting in trouble.'" The report further listed, that during an interview 7/2/15 the DON and SW meet with NA-D, who stated she "reported having heard from resident (R22) on 6/30, that [R22] is afraid of the girl with the blonde hair and bangs, that she is not very nice, etc. The blond hair with the bangs fits description of NA-C. The report further included that NA-C had been "implicated in previous reports 75814, 78740, and 79433 with possible "power struggles" with residents, as she tries to perform cares; received coaching in these incidents. NA-C was also involved in report 79866 but was not specifically named as AP."

Although R22 had described NA-C as the staff member who had hurt her and NA-C was caring for her and received multiple large bruises, no disciplinary action was taken, NA-C was not suspended pending the investigation. Also, there was no indication that a thorough investigation was completed by the facility to include other interviews with staff and residents.

During interview on 7/23/15, at 4:50 p.m. the DON stated she has concerns that NA-C might be doing the accusations, but stated she was not certain. The DON said, "Staff monitor [NA-C] during the night shift," and "we have nurses on that do that." The DON stated the nurses were to report if they notice anything and have concerns.

In an interview on 7/23/15, at 5:03 p.m. the SW stated she did not talk with other residents or staff

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regarding abuse allegations by R22. The DON stated, "I don't generally do that, it's not a witch hunt." The DON said, "Just because their name keeps coming up does not make them guilty." The DON also said there were issues around "data privacy and confidentiality." SW further stated when something regarding abuse allegations come up over the weekend, the nurse on duty initiates the OHFC reporting. The SW said the nurse would talk to the resident, and address any immediate concerns. Regarding NA-C, the SW stated, "At times there have been several residents she is not allowed to care for, but that does change if, during the investigation the allegation is not substantiated." The SW further stated, in regard to NA-C, after the first allegation of abuse, "a lot of coaching was done." The SW also said the coaching for NA-C was "not intensive, and there was no improvement plan initiated and no documentation of education or mentoring done."

During an interview on 7/23/15 at 5:10 p.m., the administrator said, "We have three young people working on nights, we can't suspend; there is not enough staff." The administrator further stated, " I feel the DON and SW did the right thing."

During an interview on 07/23/15, at 5:14 p.m. the DON stated NA-C was not suspended per the facility policy following the allegation made by R22 . She stated, "If I had suspended one, I would have had to suspend all three staff, then who would take care of the residents?"

During an interview on 07/24/15, 5:14 a.m., NA-E stated, " I don't work a lot of overnights unless I am mandated, but I do hear a few things." NA-E stated, "I have heard about people being super wet and I have heard that some of the girls are a

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21990	Continued From page 37 little rough, but I can't tell you who." She further stated one of the residents mentioned about a girl being rough and leaving bruises. NA-E described the staff member as they were described by the resident and stated the resident said " the girl threw me into the chair because I had to go to the bathroom again." NA-E stated she does not see the nurse a lot on nights. During interview on 7/24/15, at 5:25 a.m. LPN-H stated she works part time on the night shift. LPN-H stated she has heard from other NAs that NA-C is rough with the residents but had not witnessed it directly. LPN-H stated she was not aware that she was to monitor any staff during the night shift when she works. She further indicated she had heard R12 had reported that NA-C had slapped her and that NA-C no longer works on the North wing and thought the reason was because of the cat; not because she can not take care of any certain residents. She then stated the aides on the night shift don't work together they prefer to work on each unit alone. INJURIES OF UNKNOWN ORIGIN R39's annual MDS, dated 3/9/15, indicated she was moderately cognitively impaired. Her care plan, dated 3/30/15, indicated she required extensive assist with all activities of daily living, used a mechanical stand for transfers, and was at risk for abuse related to dementia. Review of Social Service Incident Report Form, dated 10/7/14, indicated R39 had a large, dark purple bruise on the right upper portion of her buttock and that R39 was unaware of how the bruising occurred. The report indicated R39 had been lowered to floor by staff a few days prior to	21990		

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the bruise and indicated that may have caused the injury. The incident further indicated use of anticoagulant medication (used to prevent clotting) , other injuries/incidents over an unspecified times frame, and listed the injury as "minor." The injury was not reported to OHFC.

During an interview on 7/24/15, at 12:54 p.m., the DON)stated, when R39 had been lowered to the floor it would be hard to know if injury occurred during that event but stated, R39 bruised easily due to use of anticoagulant medication so therefore the injury was not considered reportable.

Although R39 was moderately impaired and unable to recall how the bruise occurred, there was no evidence that a more in-depth investigation was completed to determine the actual cause, nor was R39's injury of unknown origin reported to the state agency.

R11's quarterly MDS, dated 4/15/15, indicated she was moderately cognitively impaired. Care plan, dated 6/3/15, indicated R11 required extensive to total assist for all activities of daily living, was cognitively impaired, and at risk for abuse related to depression.

Review of three separate Social Services Incident Report Forms indicated R11 had injuries of unknown origin. An incident form dated 10/21/15, indicated R39 had a bruise to the top of her right hand that was dark purple in color and measured 8 cm x 8 cm. The report further indicated R11 was unable to state how the injury occurred, used blood thinners and described the injury as "minor." Another Social Services Report Form,

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dated 11/4/14, indicated R11 had bruising noted to her left temple and above her left eyebrow, and was unable to state the cause of the injury. A third incident report dated 12/18/14, indicated R11 had a bruise of unknown origin to her left inner knee, dark purple in color, measuring 1 x 1 3/4. (unit of measurement was not indicated). The report further indicated R11 was unable to report the cause of the injury, use of anticoagulant medications, and the injury was considered to be " minor." None of the three bruises were reported to OHFC.

During an interview on 7/24/15, at 12:54 p.m., SW stated, R11 "had more bruising than anyone I have ever known." She stated the bruise on R11's hand may have been caused by "recent trimming of [R11's] nails." Regarding the bruise noted to R11's temple and forehead, SW stated that nursing felt the bruising was due to placement of R11's nebulizer mask, however, SW interviewed R11 who reported that she slipped and fell on her way back from supper. SW further stated R11 did not ambulate, used a Hoyer lift for transfer and there were no records of any falls and indicated the bruising was likely due to placement of R11's nebulizer mask.

During an interview on 7/24/15, at 12:54 p.m., the DON stated R11 could reliably answer when asked if bruising was related to abuse, therefore, she felt the injury was not reportable.

Although R11 was identified to be moderately cognitively impaired, and had multiple bruises at different locations, and were unable to determine what happened, there was no indepth investigation completed to determine the actual causes of R11's bruises. The facility administrator was notified but none of these incidents were

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21990	Continued From page 40 submitted to the state agency. R66's quarterly MDS, dated 1/7/15, indicated she was moderately cognitively impaired. Care plan, dated 2/9/15, indicated R66 required extensive assist of two staff with use of mechanical lift for transfers, at risk for delirium, and at risk for abuse related to depression. During review of a Social Service Incident Referral Form, dated 2/3/15, a facility progress noted indicated R66 had bruising along both arms from her hands to her shoulders. The form further indicated R66 was unable to state the cause of the injury and that the injury was assessed to be "minor." The injury was not reported to OHFC. During an interview on 7/24/15, at 12:54 p.m., SW stated, the bruises were noted while the DON was reviewing a progress note and she spoke with nursing and determined the bruising was assessed to be a minor injury and therefore not reportable to to OHFC. During an interview on 7/24/15, at 12:54 p.m., the DON stated, R66 used a Hoyer lift (mechanical lift) and did not always cooperate in lift, occasionally "flailing her arms." She further stated, R66 was confused and that it would be "hard to say if R66 would have been able to to talk about how the bruising occurred after any time had passed." Although R66 had bilateral bruising from her hands to her shoulders, the injury was unwitnessed and the resident was unable to identify what happened. The facility had not immediately reported the incident to the state agency nor was a thorough investigation	21990		

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21990	Continued From page 41 completed to determine if R66 was "flailing her arms" while using the mechanical lift. R44's annual MDS, dated 6/9/15, indicated she was severely cognitively impaired. Care plan, dated 7/10/15, indicated R44 required extensive assist with activities of daily living, and was at risk for abuse related to short term memory loss and impaired decision making skills. Review of Social Service Incident Referral Form, dated 6/15/15, indicated R44 had a purple bruise on her posterior forearm measuring 6.3 cm x 7 cm that was found during her bath. The incident form indicated R66 did not state the cause of injury and that the injury was determined to be "minor."The bruise was not reported to OHFC. During an interview on 7/24/15, at 12:54 p.m., SW stated, on 8/18/14, staff reported R8 had a bruise measuring 8.5 cm in length between her thumb and forefinger from the base of the thumb to her wrist. She stated the reporting nurse did the initial evaluation and determined the bruising resulted from R8 wringing her hands, and the wringing of her hands was witnessed by staff. She further stated the injury was not reportable due to staff witness of the potential cause. A Social Services Incident Referral form was requested for this injury but was not received. During an interview on 7/24/15, at 12:54 p.m., SW stated when making a determination of whether or not to report an injury to OHFC, she refers to statutes, and uses a decision tree. SW also stated that she looks at whether a resident is able to explain the injury or if someone else saw	21990		

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it, and if there is a history of other recent falls and/or injuries. She further stated, if the nurses indicated minor injury or injury not suspicious in nature or location, it does not need to be reported.

During an interview on 7/24/15, at 12:54 p.m., the DON stated, there was no criteria for determining whether an injury was minor vs major. She further stated, the nurse finding the injuries did initial evaluation to determine the above injuries to be minor. The DON stated she would use the nurses judgement when determining if an injury was minor or major and that the RN in charge followed up on the injuries. However, she stated there was no charting in the clinical record that would show evidence that follow up had been completed.

Even though R44 was assessed to be severely cognitively impaired, had an injury of "unknown" origin, on the posterior of her arm. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency.

R8's quarterly minimum data set (MDS) identified her to be severely cognitively impaired and requiring assist of two staff for activities of daily living. CP dated 5/15/15 indicated R8 required extensive assist for activities of daily living and was at risk for abuse related to diagnosis of dementia.

A review of SSIRF dated 8/18/14, indicated R8 had a bruise measuring 8.5 cm in length between her thumb and forefinger from the base of her

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21990	Continued From page 43 thumb to her wrist. The reporting nurse did the initial evaluation and determined the bruising resulted from R8 wringing her hands, and the wringing of her hands was witnessed by staff. During an interview on 7/24/15, at 12:54 p.m., SW stated, the injury was not reportable due to staff witness of the potential cause. No further investigation of the injury was completed. The facility administrator was notified of the injury but a report was not made to the state agency. A Social Services Incident Referral form was requested for this injury but was not received. Although R8 had severe cognitive impairment, and had a bruise 8.5 cm between her thumb and forefinger from the base of her thumb to her wrist. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency. Review of the facility Vulnerable Adult Policy, revised 7/15, indicated: "It is the policy of MLHS (Mille Lacs Health System) to protect adults who are vulnerable to abuse (including verbal, physical, mental psychosocial/emotional, and sexual abuse)..." The policy further indicated: "protection will include abuse prevention plans, individual abuse prevention plans, internal reporting of all cases of suspected abuse, neglect, or financial exploitation, and external reporting to the Common Entry Point (CEP) of substantiated incidents of maltreatment." In regard to investigation of a reportable incident,	21990		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21990	Continued From page 44 the policy stated: "All alleged violations are thoroughly investigated. The facility must prevent further potential abuse while the investigation is in progress." Under the "Protection for Resident or Patient" section, the policy directed that "The alleged perpetrator (AP) will be removed from the situation. If the AP is an employee, they will be suspended until the investigation is completed," and further, "Disciplinary action will be carried out up to and including dismissal of employee/employees as appropriate." The Policy defined Injury of Unknown Origin as "...source of the injury was not observed and injury as suspicious." The policy did not expound on this definition top include CMS definitions. In regard to screening of potential employees, the policy directed "MLHS will attempt to obtain information from previous employers and/or current employers." SUGGESTED METHOD OF CORRECTION: The Administrator and/or designee could review and inservice the facility staff responsible for the investigation of allegations of abuse and neglect, to the State rules and facility policy. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21990		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its	22000		8/21/15

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22000	Continued From page 45 environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult.	22000		

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22000	Continued From page 46 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement their Vulnerable Adult Policy to ensure all allegations of abuse, neglect, mistreatment and injuries of unknown origin were immediately reported to the administrator and state agency, were thoroughly investigated, and residents were protected during the investigations for 8 of 15 residents' (R47, R12, R22, R39, R11, R66, R44 and R8) allegations reviewed. In addition, the facility failed to conduct reference checks according to their policy for 4 of 5 newly hired employees (NA-A, NA-B, DA-A and RN-B). This had the potential to effect all 50 residents who resided in the facility, and resulted in substandard quality of care under resident behavior and facility practices. Findings include: The facility Vulnerable Adult Policy, revised 7/15, indicated: "It is the policy of MLHS (Mille Lacs Health System) to protect adults who are vulnerable to abuse (including verbal, physical, mental psychosocial/emotional, and sexual abuse)..." The policy further indicated: "protection will include abuse prevention plans, individual abuse prevention plans, internal reporting of all cases of suspected abuse, neglect, or financial exploitation, and external reporting to the Common Entry Point (CEP) of substantiated incidents of maltreatment." In regard to investigation of a reportable incident, the policy stated: "All alleged violations are thoroughly	22000	corrected 8/21/15	

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22000	Continued From page 47 investigated. The facility must prevent further potential abuse while the investigation is in progress." Under the "Protection for Resident or Patient" section, the policy directed: "The alleged perpetrator (AP) will be removed from the situation. If the AP is an employee, they will be suspended until the investigation is completed," and further, "Disciplinary action will be carried out up to and including dismissal of employee/employees as appropriate." INVESTIGATION AND PROTECTION During interview 7/23/15, at 5:09 p.m. with social worker (SW) stated that nursing assistant (NA)-C has been implicated in at least four incident reports from February 2015 to July 2015 of alleged abuse, and neglect. Review of facility Incident and Investigation reports from 2/1/2015 to 7/20/2015 for NA-C identified the following: R47's quarterly minimum data set (MDS) dated 2/17/15, indicated she was moderately cognitively intact and needed extensive assistance in ADLs. R47's care plan dated 2/26/15, indicated she had dementia and needs assist with dressing, grooming and bathing. The care plan further indicated she had slight alteration in cognition related to dementia and that resident will continue to be oriented to person, place and time. A facility Social Service Incident Referral Form (SSIRF) indicated licensed practical nurse (LPN)-D verbally reported to the social worker (SW) on 1/27/2014, at 4 p.m., an incident that occurred during the night shift on 1/24/2015. The SSIRF, dated 1/27/15, indicated: "Alleged altercation/conflict between res [resident] & aides resulting in resident slapping aide and stating 'I	22000		

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22000	Continued From page 48	22000		

didn't hit you, you hit me you liar.'" The SSIRF also indicated, "LPN separated aide & resident, assisted res to bed, escorted aide to hallway to inquire what happened." The SSIRF also indicated the incident required "further investigation and/or reporting" to the state agency, and this was signed by the SW on 1/28/15.

A review of Mille Lacs Nursing Home Progress Notes, dated 1/28/15, written by LPN-D indicated: "This nurse was in a res. room, 5 rooms away from where the incident happened, but heard a distinct smack. Followed by a woman's out cry. This nurse then got a call on the walkie [walkie-talkie] from the aide (nursing assistant, NA)." The [NA] stated (in her words) "On 2 a.m. rounds, I went to check resident in room 45-1 (room 45, bed 1) and woke up resident in 45-2 [R47] in the process. I told [R47] the time and said she should lay back down and try and get some sleep until coffee time." [R47] said "No, I want to sit up I'm waiting." NA said "No lets lay down" and NA went to pick up [R47's] feet to bring them in bed and [R47] swung and hit me in the head, fairly hard. I [NA] yelled out "ow" and NA said "why did you hit me, [R47] said, 'I didn't, you hit me you liar' then [NA] walked out and walkie the nurse...." This nurse [LPN-D] asked the res. why she hit the aide. Res. [R47] stated that the aide hit her." The nursing note did not identify the nursing assistant by name.

A facility email, written by the SW, dated 1/28/2015, indicated the SW had been verbally informed by LPN-D of R47 being in a conflict with a nursing assistant. The email indicated there was a progress note of the incident, but no further "incident report form." The email indicated the SW further reviewed the progress notes, and

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because the notes indicated "the resident allegedly struck a NAR [nursing assistant] and also that the resident claimed at the time that the NAR struck her, the incident DOES need to be reported" to the state agency.

An Incident Report submitted to the state agency on 1/28/15, indicated: "An incident was verbally reported to this SW in the late afternoon 1/27/15..." and further that R47 had a conflict "this past weekend" with a nursing assistant. Following a review of the related progress notes by the "Stand Up Team" and "Behavior Management Team", it was originally determined incident was due to [R47's] "dementia symptoms..." The report referred to a nursing progress note which indicated that [R47] "claimed at the time that the NAR struck her," thus requiring a report to the state agency, and "an internal investigation done accordingly as per policy." The alleged perpetrator (AP) was unidentified.

A review of the SSIRF, the internal email, and the initial report submitted to the state agency indicated an incident occurred sometime during the night shift/early morning hours of 1/25/14. The report also indicated the incident was first reported, and made known to the SW on late afternoon of 1/27/2014, (two days after the incident) and reported to the state agency on 1/28/2015 (three days after the incident allegedly occurred). There was no indication this incident was reported immediately to the administrator and state agency. Additionally, the investigation of this incident: lacked timely interviewing of NA-C, and other involved staff, and potentially affected residents; did not provide evidence R47 was thoroughly investigated for injuries; and lacked evidence of action to protect residents

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22000	Continued From page 50 during the investigation. A final Investigative Report was submitted to the state agency on 2/2/15. The report indicated the SW met with R47 "on the a.m. of 1/28/15 and 1/30/15," and "Resident unable to recall any incidents of concern with any aides the previous weekend." The SW was unable to speak with NA-C, (identified as the nursing assistant involved) until 2/2/15 (7 days after the SW learned of the incident) "in part due to her work schedule not coinciding with the SW." SW spoke with NA-C by phone on 2/2/15, at 10:45 p.m. NA-C "acknowledged the incident happened as described" by LPN-D's note, and further, "[NA-C] saying she had not struck resident in any way, but had merely tried to lift [R47's] legs to help her lay back down..." The report indicated "There is no apparent evidence of NAR striking resident." The investigative report indicated the alleged perpetrator was NA-C. This report also included that NA-C had been implicated in a previous submitted report. During an interview 7/23/15, at 5:10 p.m., the SW stated in the investigation, R47 was unable to recall if the incident had happened, and that R47 had dementia. The SW said NA-C was not suspended during her investigation because it could not be proven that NA-C abused R47, and NA-C continued to be on the work schedule. The SW said NA-C was counseled on how to provide cares for R47, and was asked for ideas from NA-C on how to keep R47 safe. Review of the facility's MLHS-LTC NA/R Schedule from January 26, 2014 to February 8, 2015, indicated NA-C worked on the night shift on 1/28/15 and 1/29/15, while the investigation of	22000		

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22000	Continued From page 51 this incident was in progress. R47 had another facility Social Service Incident Referral Form (SSIRF), signed by RN-C indicated R47 was involved in an incident on "3/2/15 early a.m., of possible abuse or resident aggression." The SSIRF indicated: RN-C noted PCC notes (electronic progress notes) by LPN-B questioning verbal statements and other behaviors by resident [R47]; possible indication of maltreatment but just a likely symptoms of resident's dementia." The SSIRF further indicated the incident was discussed with Investigative Team on 3/3/15 at 8:30 a.m., and reported submitted to the state agency on 3/3/2015 at 12:30 p.m. The report also indicated NA-C was a person with credible knowledge of the situation. An initial Incident Report was submitted to the state agency on 3/3/15 regarding possible maltreatment of R47 on 3/2/15. The report referenced "two progress notes from NOC (night) shift early that a.m. of 3/2 that suggests either some behavioral concerns/dementia symptoms by resident [R47] at work or possible maltreatment of resident by staff." The report indicated uncertainty by staff on whether this was maltreatment, and "SW decided to go ahead and submit the allegation to [state agency]...." A nursing progress note, dated 3/2/215 at 4:03 a.m., written by LPN-B, indicated [R47] was "kicking at staff" and [R47] told staff "she was going to report 'her' to the nurse.." The note also indicated R47 told staff "you go around hitting everyone I heard.." On 3/2/15 at 6:03 a.m., a second progress noted indicated staff went to wipe dry blood off [R47's] lip, and [R47] hit staff.	22000		

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22000	Continued From page 52 The note continued, that after R47 hit staff, R47 stated "I am going to report you for hitting me." Facility documentation did not indicate any action was taken to protect R47 and other residents during this investigation of potential abuse. Documentation of the investigation of this incident did not include determination the cause of R47's bloody lip, and there was no evidence of interview with the nursing assistant who provided cares for R47. The SSRIF also indicated there was no immediate reporting of this incident to the state agency or administrator. A final, Investigative Report was submitted to the state agency on 3/06/15 regarding the incident. The report indicated on 3/2/15 the "resident was interviewed by RN Care Coordinator (RN- A) and this SW. Resident denied remembering anything happening this past weekend during the daytime or the nighttime that upset her in any way.....She denied that anyone hits her or has been mean to her or that she has hit anyone else." The report also indicated "SW communicated with [LPN-B] about progress notes from 3/2/15 during night shift, "indicating the NAR was situating resident in the EZ lift (mechanical lift) to help her to the bathroom per resident's request and the NAR noticed resident's lip had been bleeding apparently cracked from being chapped with dry, winter air. [NA-C] told [R47] she was going wipe the dried blood off, but R47 struck out at NA, causing NA's glasses to dismount from her face." The report indicated NA-C re-approached later and assisted [R47] without incident. Later the same night, the NA was doing rounds and attempted to lift R47's feet back in bed, and resident kicked at NA-C. The report then referenced the allegations made by R47, that she was slapped. The report did not confirm a	22000		

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22000	Continued From page 53 perpetrator in this incident. The report indicated R47's care plan was reviewed, and suggestions were made on how to approach R47 during cares. The report also indicated LPN-B was coached by the SW and DON on more thorough progress note charting, and further, that staff have been reminded to submit timely incident reports. The report included: "Something is just not resting well with this, and although there is no maltreatment of residents 'substantiated' in this particular incident, SW will continue to keep eyes and ears open for patterns and/or trends in conduct, etc." Review of the facility's MLHS-LTC NA/R Schedule from February 23, 2015 to March 8, 2015, indicated NA-C was assigned to work 3/2/15 (the night of the alleged incident) and also worked on 3/3/15. During interview 7/23/15, at 5:30 p.m. the SW stated, in review of this incident, she had "concerns with NA-C" but again could not prove she had really done anything wrong. The facility felt they could not substantiate the allegations against NA-C, and therefore did not warrant a "suspension or discipline" during the investigation. There was no indication that a thorough investigation was completed for R47. R12's quarterly MDS dated 4/27/15 indicated she was moderately, cognitively intact and needed extensive assist with dressing, bathing and grooming. R12's care plan dated 1/31/15, indicated she had potential for abuse from others related to cognitive impairment and limited mobility.	22000		

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22000	Continued From page 54 A facility Social Service Incident Referral Form (SSIRF), signed by the SW 2/18/15 at 4:15 p.m., indicated there was an incident on "2/18/2015 early A.M.", which alleged "Abuse." The incident was described as: "[NA)-I] asked SW to meet w/ Res re some issues. 9:30 a.m. Res told SW 'I want to go home, they're mean to me here.' 'The lady with the ponytail hurt me when she clean me up yesterday', and 'The other lady slapped me when she tried to make me drink white stuff.' At 4p.m. resident [R12] was still claiming similar concerns." The SSIRF also indicated the following: an internal email report was completed on 2/18/15; that the report of alleged abuse was received by the SW in person, no date or time listed; the incident was discussed with "Investigative Team" on 2/18/15 at 0833; and that the state agency initial report was submitted on 2/18/15 (no time indicated). An initial Incident Report submitted to the state agency on 2/18/15, indicated on 2/18/15, R12 was "slapped on her cheek by a staff person early this morning while staff person was trying to get her to take some medicine." The report indicated R12 had no apparent injuries, and "has been consistent with this claim throughout the day..." The report also indicated "a full internal investigation is warranted." The "alleged perpetrator" on the report form was listed as "unknown." A review of the SSIRF, and the initial report to the State Agency indicated, that although this incident occurred in the early morning of 2/18/15, and possibly earlier, no action was taken by the facility or staff until it was discussed later that morning on 2/18/15. There was no indication the incident was immediately reported to state agency and administrator. Further, the investigation	22000		

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documentation of this incident did not indicate if R12 was slapped; and there was no follow up to have R12 positively identify the nursing assistant, (possibly NA-C) who provided her cares that day. Although NA-C was instructed not to enter R12's room without a colleague present, the documentation offered no indication protections were put in place for other residents who were assisted by NA-C during the investigation of this incident, regardless of its outcome.

A final Investigative Report was submitted to the state agency on 2/23/15. The final report indicated the "Initial Reports submitted to [state agency] ...at 4 p.m.," on 2/18/15, and also a call was made to local law enforcement. The report indicated R12 had made numerous allegations, but the only allegation that could be "tracked, was the one about someone slapping her during the administration of Milk of Magnesia (MOM) that morning (the white stuff)." The report indicated SW and DON proceeded to seek more information about who would have administered the MOM that morning. The report identified, according to the schedule, LPN-B and NA-C were the persons on duty. Further, the report indicated, "DON and SW met with [NA-C], who freely admitted having given MOM upon the direction of [LPN-B]." The report continued, "[NA-C] said resident didn't want the MOM, and resident took the cup and threw the MOM all over." and "[NA-C] tried to clean it up off the bedding, resident's clothing and her face, using wet wipes." The report indicated "[NA-C] denied slapping resident in any way, but acknowledged wiping R12's face off with the wet ones." The report indicated "It is possible this was perceived by [R12] as a slap." Next, the report indicated, the SW asked NA-C to go to resident's room to

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see if resident could or would identify her as the lady who slapped her, and NA-C agreed to do so. "[R12] was sleeping soundly, however, so decided not awaken her." The report indicated "NA-C's willingness to go, however, leads SW to believe she [NA-C] is being truthful about not slapping resident." The report indicated the DON spoke to LPN-B by phone on 2/23/15 at 3:20 p.m. LPN-C admitted asking NA-C to give MOM to R12 due to LPN-C being occupied elsewhere LPN-C also acknowledged that NA-C did report (R12's) claim of being slapped by a "blonde lady." The report then indicated staff have been alerted to having "two persons present" during cares with this resident and NA-C was instructed not to enter room without a colleague present.

During interview on 7/23/15, at 5:20 p.m. the SW stated she did not suspend NA-C since "they could not prove [NA-C] slapped [R12.]" The SW acknowledged NA-C had been involved in multiple incidents, and had "suspicions" with [NA-C], but did not feel "there was a reason to suspend" or provide disciplinary action to her during this investigation.

Review of the facility's MLHS-LTC NA/R Schedule from February 9, 2015 to February 22, 2015, indicated NA-C worked on 2/17/15 through 2/22/2015, that is on the date of the alleged incident, and during the subsequent investigation. There was no indication a thorough investigation was completed for R12.

R22's admission MDS dated 4/24/15, indicated she had depression and a cerebral vascular accident (CVA), and was moderately cognitively impaired and needed limited assist with transfers

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MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

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22000	Continued From page 57 and extensive assist with toileting. R22's care plan dated 5/3/15, indicated she needed assist with toileting and transfers, had history of depression and sadness/isolating self. R22's care plan further indicated she had potential for abuse from others related to her general weakness, aches and pains. The care plan goal indicated "resident will remain safe and have needs met in a safe environment." During observation on 7/20/15 at 5:54 p.m., R22 lifted her pant leg and displayed a bruise on her right shin measuring approximately 8 cm (centimeters) x 2 cm. R22's bruise was noted to be black, fading to dark purple in color, with no apparent swelling. In an interview 7/20/15, at 5:54 p.m. R22 stated that she had been treated "roughly by the staff" and there is "a staff member who works the night shift that is rough with her." R22 went on to state this staff member had "grabbed her arm when transferring" which caused a large bruise and also stated she had also hit her leg into the metal bar along the bottom of her bed. The facility submitted an Incident Report to the state agency on 6/27/15 regarding an incident of alleged mistreatment and physical abuse of R22. The report also identified a bruise on R22 top right hand, measuring 5.5 cm x 5 cm, circular in shape; and a second bruise on R22's lower right shin 2.5 cm x 2.5 cm, circular in shape. The report was submitted by RN-D, and indicated that the initial reporter, NA-C, was also the alleged perpetrator in this incident. The report indicated, nursing assistant (NA)-C reported at 5:15 a.m., she had toileted R22, after being toileted, R22 told [NA-C] she was not coming back tonight,and that "some girl hurt her." NA-C asked who, and she [R22] stated she doesn't know who. The	22000		

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report then indicated that registered nurse (RN)-A, followed up with R22 in the morning and asked her to tell her what happened: "Resident reported she is not staying her again tonight and is not going to be treated like this anymore." R22 explained that staff was mad at her during the night for getting up to use the bathroom so many times, and that a "girl grabbed me and threw me into bed." R22 pointed out her hand hurt, and said "this is where she grabbed me," noted a bruise on top of right hand measures 5.5 cm (centimeters) x 5 cm circular is shape. R22 also reported when she threw me into bed, "I hit my leg on something metal" a bruise noted on right outer lower shin measures 2.5 cm x 2.5 cm circular in shape. R22 could not recall who the girl was, nor her name. R22 thought it was around 0400. The report further indicated NA-C was the nursing assistant working on that wing during the night, and LPN-A was the nurse in charge. No other injuries noted, resident was reassured she will remain safe here, NA-C will be removed from working with resident at this time.

An additional Incident Report was submitted to the state agency on 7/1/15, which identified an injury of unknown source on R22's right forearm "8 x 5 cm, reddish purple in color and oval in shape." The date of incident occurrence was unknown. The report indicated R22 said "It happened a few days ago."

An Investigative Report was submitted to the state agency on 07/02/15, which combined two submitted incident reports dated 6/27/15 and 7/1/15. The report indicated the director of nursing (DON) and social worker (SW) "have tried to investigate this issue thoroughly and have been unable to substantiate who the alleged perpetrator [AP] is for certain, but have reached a

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22000	Continued From page 59 conclusion there is reasonable suspicion a crime may have occurred in the form of assault, and are hence submitting a report also to law enforcement, in accordance with Elder Justice Act." Further the report indicated, "The details of our internal investigation to the limits of our ability are being submitted to OHFC and the state agency." The Investigative Report further indicated on 7/1/15, the DON and SW met with the AP, (NA-C) who stated R22 had requested to use the toilet 6-8 times that night (6/27/15). The report then indicated [SW and DON] "discussed with the AP the number of previous incidences involving this NAR, which can raise red flags re her credibility, and she became somewhat defensive, face reddening and voice tightening, saying 'it's because I report things and others don't, so I end up getting in trouble.' " The report further listed, that during an interview 7/2/15 the DON and SW meet with NA-D, who stated she "reported having heard from resident (R22) on 6/30, that [R22] is afraid of the girl with the blonde hair and bangs, that she is not very nice, etc. The blond hair with the bangs fits description of NA-C. The report further included that NA-C had been "implicated in previous reports 75814, 78740, and 79433 with possible "power struggles" with residents, as she tries to perform cares; received coaching in these incidents. NA-C was also involved in report 79866 but was not specifically named as AP." Although R22 had described NA-C as the staff member who had hurt her and NA-C was caring for her and received multiple large bruises, the incident documentation indicated no action taken to protect residents during investigation of these incidents. Also, there was no indication that a thorough investigation was completed that included other interviews with staff and residents.	22000		

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22000	Continued From page 60 During interview on 7/23/15, at 4:50 p.m. the DON stated she "has concerns that NA-C might be doing the accusations," but stated she "was not certain." The DON said, "staff monitor [NA-C] during the night shift," and also "we have nurses on that do that." The DON stated the nurses were to report to her if they notice anything and have concerns. In an interview on 7/23/15, at 5:03 p.m., the SW stated she "did not talk with other residents or staff regarding abuse allegations by [R22]." The DON stated, "I don't generally do that, it's not a witch hunt." The DON said, "Just because their name keeps coming up does not make them guilty." The DON also said there were issues around "data privacy and confidentiality." SW further stated, when something regarding abuse allegations come up over the weekend, the nurse on duty initiates the OHFC reporting. The SW said the nurse would talk to the resident, and address any immediate concerns. Regarding NA-C, the SW stated, "At times there have been several residents she is not allowed to care for, but that does change if, during the investigation the allegation is not substantiated." The SW further stated, in regard to NA-C, after the first allegation of abuse, " a lot of coaching was done." The SW also said the coaching for NA-C was "not intensive, and there was no improvement plan initiated and no documentation of education or mentoring done." During an interview on 7/23/15 at 5:10 p.m., the administrator said, "We have three young people working on nights, we can't suspend; there is not enough staff." The administrator further stated, " I feel the DON and SW did the right thing."	22000		

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22000	Continued From page 61 During an interview on 07/23/15, at 5:14 p.m., the DON stated NA-C was not suspended per the facility policy following the allegation made by R22 . She stated, "If I had suspended one, I would have had to suspend all three staff, then who would take care of the residents?" During an interview on 07/24/15 5:14 a.m., NA-E stated, " I don't work a lot of overnights unless I am mandated, but I do hear a few things." NA-E stated, "I have heard about people being super wet and I have heard that some of the girls are a little rough, but I can't tell you who." She further stated, one of the resident mentioned about a girl being rough and leaving bruises. NA-E described the staff member as they were described by the resident and stated the resident said " the girl threw me into the chair because I had to go to the bathroom again." NA-E stated she does not see the nurse a lot on nights. During interview on 7/24/15, at 5:25 a.m. LPN-H stated she works part time on the night shift. LPN-H stated she has heard from other NAs that NA-C is rough with the residents but had not witnessed it directly. LPN-H stated she is not aware that she is to monitor any staff during the night shift when she works. She further indicated she had heard R12 had reported that NA-C had slapped her and also that NA-C no longer works on the North wing and thought the reason was because of the cat not because she can not take care of any certain residents. She then stated the aides on the night shift don't work together they prefer to work on each unit alone. INJURIES OF UNKNOWN ORIGIN The facility Vulnerable Adult Policy, revised 7/15, defined Injury of Unknown Origin as "...source of	22000		

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the injury was not observed and injury as suspicious." The policy did not expound on this definition to include criteria from the CMS interpretive guidance.

R39's annual MDS, dated 3/9/15, indicated she was moderately, cognitively impaired. The CP, dated 3/30/15, indicated R39 required extensive assist with all activities of daily living (ADLs), used a mechanical stand for transfers, and was identified at risk for abuse, because of dementia.

A review of SSIRF dated 10/7/14, indicated R39 had a large, dark purple bruise on the right upper portion of her buttock, and it was an "unknown" injury, and R39 was "unaware" of how the bruising occurred. The SSIRF also indicated R39 "a few days ago had been lowered to floor due to not standing when transferring & then lifted with Hoyer (a mechanical lift) Possible cause." The SSRIF further indicated R39 used a medication that could explain bruising, and also that R39's chart contained "falls or other recent incidents that could likely have produced the injury." The SSIRF indicated R39's injury was "minor" and not reported to the state agency. No further investigation was completed for this incident even though there was no indication R39 had struck any objects or the floor as she was lowered to the ground.

During an interview on 7/24/15, at 12:54 p.m., the DON stated, when R39 had been lowered to the floor "it would be hard to know if injury occurred during that event." The DON said R39 bruised easily due to use of anticoagulant medication, so therefore the injury was "not considered reportable."

Although R39 was moderately impaired and

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22000	Continued From page 63 unable to recall how the bruise occurred, there was no evidence that a more in-depth investigation was completed to determine the actual cause, nor was R39's injury of unknown origin reported to the state agency. R11's quarterly MDS, dated 4/15/15, indicated she was moderately, cognitively impaired. The CP, dated 6/3/15, indicated R11 required extensive to total assist for all ADLs, and was at risk for abuse related to depression. A review of SSIRF dated 10/21/15, indicated R39 had a bruise to the top of her right hand, dark purple in color, and measured 8 cm x 8 cm. The SSIRF indicated R11 was unable to state how the injury occurred, but R11 used anticoagulant medication, and R11's bruise was described as "minor." The facility administrator was notified but no report was made to the state agency. A second SSIRF, dated 11/4/14, indicated R11 had bruising noted to her left temple and above her left eyebrow. The SSIRF indicated R11 was unable to state the cause of the injury. The facility administrator was notified, but the injury was not reported to the state agency. A third SSIRF dated 12/18/14, indicated R11 had a bruise of unknown origin to her left inner knee, dark purple in color, and measuring 1 x 1 3/4 inches. The SSIRF indicated the injury was "unknown", that R11 was unable to report the cause of the injury, used anticoagulants; and also indicated the injury was considered to be "minor." The facility administrator was notified, but the injury was not reported to the state agency.	22000		

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22000	Continued From page 64 During an interview about the three injuries of unknown origin on 7/24/15, at 12:54 p.m., the SW stated, R11 "had more bruising than anyone I have ever known." The SW said the bruise on R11's hand "may have been caused by recent trimming of [R11's] nails," indicating R11 caused the bruise herself. Regarding the bruise noted to R11's temple and forehead, the SW stated that nursing felt the bruising "was due to placement of [R11's] nebulizer mask," however, the SW stated, she interviewed R11 who reported that she slipped and fell on her way back from supper. SW further stated R11 did not ambulate, used a Hoyer lift [a mechanical lift] for transferring, and there were no records of any falls. SW added the bruising was "likely due to placement of [R11's] nebulizer mask." No further investigation was completed for this injury. During an interview on 7/24/15, at 12:54 p.m., the DON stated R11 "could reliably answer" when the reporting nurse asked if bruising was related to abuse, therefore, the DON felt the injury was not reportable. Although R11 was identified to be moderately cognitively impaired, and had multiple bruises at different locations, there was no indepth investigation completed to determine the actual causes of R11's bruises. The facility administrator was notified of the injuries but none of these incidents were submitted to the state agency. R66's quarterly MDS, dated 1/7/15, indicated she was moderately, cognitively impaired. The CP, dated 2/9/15, indicated R66 required extensive assist of two staff, with use of a mechanical lift, for transfers. The CP also indicated R66 was at	22000		

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22000	Continued From page 65 risk for delirium and potential abuse, related to depression. A review of SSIRF dated 2/3/15, indicated during a review of R66's nursing progress note dated 1/26/2015, there was "presence of unknown bruises" on [R66] both arms, the size was identified as bruising "from hands to shoulder." The SSIRF also indicated R66 now wore sleeve/arm protectors. The SSIRF indicated this was an "unknown injury", that R66 was unable to state the cause, and that the injury was assessed to be "minor." The injury was reported to the facility administrator, but was not not reported to the state agency. During an interview on 7/24/15, at 12:54 p.m., the SW stated, the bruises were noted while the DON was reviewing R66's progress notes. The SW said she "spoke with nursing" and determined the bruising was assessed "to be a minor injury, and therefore not reportable to the state agency." During an interview on 7/24/15, at 12:54 p.m., the DON said R66 used a Hoyer lift (mechanical lift), and R66 did not always cooperate in lift, occasionally "flailing her arms." The DON further stated R66 was confused, and that it would be "hard to say if R66 would have been able to to talk about how the bruising occurred after any time had passed." Although R66 had bilateral bruising from her hands to her shoulders, the injury was unwitnessed and the resident was unable to identify what happened. The facility had not immediately reported the incident to the state agency nor was a thorough investigation completed to determine if R66 was "flailing her arms" while using the mechanical lift.	22000		

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22000	Continued From page 66 R44's annual MDS, dated 6/9/15, indicated she was severely cognitively impaired. The CP, dated 7/10/15, indicated R44 required extensive assist with ADLs, and was at risk for abuse, related to short term memory loss and impaired decision-making skills. A review of SSIRF dated 6/15/15, indicated R44 had a purple bruise on her posterior (back side) forearm, measuring 6.3 cm x 7 cm, that was found during her bath. The SSIRF indicated this was an "unknown" injury, and R66 could not state the cause of injury. The injury was determined to be "minor". The facility administrator was notified, but the injury was not reported to the state agency. During an interview on 7/24/15, at 12:54 p.m., the SW stated, "The injury was determined by nursing staff to be 'minor' and did not meet any suspicious criteria. The SW said she "did not see a need to report" to the state agency. In an interview on 7/24/15, at 12:54 p.m., the DON stated, "[R44] would have been able to tell you if something happened, she could make her needs known." Even though R44 was assessed to be severely cognitively impaired, had an injury of "unknown" origin, on the posterior of her arm. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency.	22000		

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22000	Continued From page 67 R8's quarterly minimum data set (MDS) identified her to be severely cognitively impaired and requiring assist of two staff for activities of daily living. CP dated 5/15/15 indicated R8 required extensive assist for activities of daily living and was at risk for abuse related to diagnosis of dementia. A review of SSIRF dated 8/18/14, indicated R8 had a bruise measuring 8.5cm in length between her thumb and forefinger from the base of her thumb to her wrist. The reporting nurse did the initial evaluation and determined the bruising resulted from R8 wringing her hands, and the wringing of her hands was witnessed by staff. During an interview on 7/24/15, at 12:54 p.m., SW stated, the injury was not reportable due to staff witness of the potential cause. No further investigation of the injury was completed. The facility administrator was notified of the injury but a report was not made to the state agency. A Social Services Incident Referral form was requested for this injury but was not received. Although R8 had severe cognitive impairment, and had a bruise 8.5cm between her thumb and forefinger from the base of her thumb to her wrist. There was no indication the facility completed an thorough investigation to determine the source of her injury, also the incident was not reported to the state agency. During an interview on 7/24/15, at 12:54 p.m., SW stated, when making a determination of whether or not to report an injury to the state agency, she "refers to statutes, and uses a	22000		

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22000	Continued From page 68 decision tree." The SW also stated that she looks at whether a resident is able to explain the injury, or if someone else saw it, and if there was a history of other recent falls and/or injuries. The SW further stated, "If the nurses indicated minor injury or injury not suspicious in nature or location, it does not need to be reported." During an interview on 7/24/15, at 12:54 p.m., the DON said, minor injuries are not reportable to the state agency. She further stated, there was "no criteria or policy" the facility has to identify and determine whether an injury was "minor" versus "major." The DON also stated she "would use the nurses judgement" when determining if an injury was minor or major, and that the RN in charge "followed up on the injuries." However, she stated there was no charting on the clinical record that would show evidence that follow-up had been completed. REFERENCE CHECKS The facility's Abuse Prevention Policy, revised 7/15, indicated as its purpose "...to protect adults who are vulnerable to abuse..." Further, the policy included: "To assure the facility was doing everything within its control to prevent the occurrence of abuse or neglect...the facility would attempt to obtain information from previous employers and or/current employers." NA-A's personnel record identified they were hired on 7/13/15. The personnel record lacked evidence reference checks were completed prior to employment at the facility. NA-B's personnel record identified they were hired on 6/30/15. The personnel record lacked evidence reference checks were completed prior to employment at the facility.	22000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00374	A. BUILDING: _____ B. WING _____	07/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLE LACS HEALTH SYSTEM	200 NORTH ELM STREET ONAMIA, MN 56359

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
22000	Continued From page 69 Dietary Aide (DA)-A's personnel record identified they were hired on 6/23/15. The personnel record lacked evidence reference checks were completed prior to employment at the facility. Registered nurse (RN)-B's personnel record identified they were hired on 5/11/15. The personnel record lacked evidence reference checks were completed prior to employment at the facility. On 7/23/15, at 8:45 a.m. human resources (HR) staff stated four of the five newly hired employees did not have documentation of reference checks. HR stated there was "not a process" to document that reference checks had been completed. They facility used the application references "to inquire about the position held, date of hire, eligibility for rehire and any feedback." SUGGESTED METHOD OF CORRECTION: The Administrator and/or designee could review and inservice facility staff to their policy in regard to abuse and neglect TIME PERIOD FOR CORRECTION: Fourteen (14) days.	22000		