Electronically delivered

February 25, 2022

Administrator
The Emeralds at Faribault LLC
500 Southeast First Street
Faribault, MN 55021

RE: CCN: 245067
Cycle Start Date: January 11, 2022

Dear Administrator:

On January 21, 2022, we informed you that we may impose enforcement remedies.

On February 3, 2022, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted immediate jeopardy (Level K), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On January 26, 2022, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. Past non-compliance does not require a plan of correction (POC).

REMEDIES

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

this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 11, 2022

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of

payment for new admissions is effective April 11, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 11, 2022.

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

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

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

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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.

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by April 11, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Emeralds At Faribault LLC will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 11, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may

contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 11, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 25, 2022

Administrator
The Emeralds At Faribault LLC
500 Southeast First Street
Faribault, MN 55021

Re: State Nursing Home Licensing Orders
Event ID: TUS911

Dear Administrator:

The above facility was surveyed on January 31, 2022 through February 3, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245067	A. BUILDING _____ B. WING _____	C 02/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT FARIBAULT LLC	500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/31/22 through 2/3/22, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The following complaint was SUBSTANTIATED at F600 for PAST NON-COMPLIANCE. H5067096C (MN00080526 and MN00080467). However, related deficiencies were cited at F610 and F758. The following complaint was SUBSTANTIATED H5067097C (MN80583) with deficiencies cited at F839. The immediate jeopardy began on 1/22/22 when R1 touched R4's breast under her shirt and the director of nursing (DON) was notified. R1 touched R4's breasts a second time on 1/25/22. The administrator, and director of nursing (DON) were notified of the IJ on 2/3/22 at 1:00 p.m and the facility implemented corrective action on 1/26/22 prior to the start of the survey and was issued at Past Noncompliance. Although the provider had implemented corrective action prior to survey, harm or immediate jeopardy was sustained prior to the correction. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents. The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/07/2022

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F 000	Continued From page 1 Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an 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.	F 000		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to immediately implement appropriate interventions to protect residents from sexual abuse from R1 who had sexual behaviors that were inflicted on 5 residents (R4, R2, R3, R5, and R6) in the facility which resulted in a potential risk of serious harm identifying	F 600	Past noncompliance: no plan of correction required.	2/25/22

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F 600	Continued From page 2 immediate jeopardy. The immediate jeopardy began on 1/22/22 when R1 touched R4's breast under her shirt and the director of nursing (DON) was notified. R1 touched R4's breasts a second time on 1/25/22. The administrator, and director of nursing (DON) were notified of the IJ on 2/3/22 at 1:00 p.m and the facility implemented corrective action on 1/26/22 prior to the start of the survey and was issued at Past Noncompliance. Findings include R1's admission Minimum Data Set (MDS) dated 10/21/21, indicated R1 did not have cognitive impairment and did not have behaviors. The MDS identified R1 was independent with locomotion on and off he unit. R1's mood care plan dated 10/21/21, included "Resident has an alteration in mood and behavior related to Alzheimer's dx [diagnosis] loss of independence. Has also has a hx [history] of making sexually inappropriate comments towards staff and residents. Associated interventions dated 10/21/21 included, be alert to mood and behavioral changes, medications per physician order, redirect as needed (added 11/1/21), social services to assist resident (added 11/1/21) and monitor and document on mood state (added 11/1/21). The care plan also identified R1 watched pornography in his room. The care plan did not specifically identify or address level of supervision and/or while around female residents and/or individualized interventions to prevent R1 from voicing inappropriate comments to female residents.	F 600		

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F 600	Continued From page 3 R1's behavior progress note dated 12/7/21 indicated R1 attempted to go into R2's room, staff had to remind him he was not allowed in R2's room. "He stated "Oh I forgot". He then left and went to the common area on the unit where he sat and talked with resident [R3]. He asked this resident what room number she is staying. R1 followed her to her room and started to go in. TMA [trained medication assistant] had to remind him once again that he is to not go into anyone's room." R1's social services note dated 12/8/21, included "Staff have been reporting that resident has been flirting with other residents and attempting to go into other residents' rooms. Resident does have a history of sexual behaviors towards staff at his previous facility. Staff have concerns that resident will begin to display sexual behaviors towards residents." The note indicated the social worker notified R1's power of attorney who would have a conversation with R1 and social worker "encouraged resident to continue being social and making new friends but it needs to remain appropriate and can be done in common areas within the building. Resident thanked writer and said he understood. Staff will continue to monitor and report any further behaviors. R1's social services note dated 12/9/21, included "Activities staff reported to writer that she found resident in [R2's] room. Resident was asked again to visit with residents in common areas. Writer later chatted with [R2] who reported that she did not invite [sic] him in he had just showed up and came into her room" There was no indication of inapposite behavior between R1 and R2.	F 600		

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F 600	Continued From page 4	F 600		

R1's physician visit note dated 1/17/2022 indicated "nursing notes that he is frequently looking at porn on his phone" The physician note did not address the sexual behaviors identified in the progress note and did not identify the plan for behavioral management.

R1's quarterly MDS dated 1/21/22, identified R1 did not have cognitive impairment and did not have behaviors.

R1's progress note dated 1/22/22, at 7:22 p.m. included "Resident [R1] seen in the hall at 70's with one of 70's resident [R4]. Resident wanted to touch other resident's breast. When I heard conversation, I warned him not to do anything, and told him they should be 6 feet apart. I continued to watch his behaviors. Resident did not listen and start to touch the other resident's breast under her shirt. Resident taken into his room and immediately informed the DON. The DON called and told us to tell him that he is not allowed to come out from his room for the rest of the night. Resident stated that he did not care outcomes. Resident will be monitored and he will not be out his room for the rest of the night."

R1's late entry progress note created on 1/25/22 by the administrator for effective date of 1/24/22 at 4:33 p.m. included "[Staff member] was working on 1/24/22 and noticed the resident was in a female resident's room alone. [Staff] immediately went to the room that he was in and told him that he couldn't be in there. [Staff] noticed that resident near the females' residents' bed while she was laying in her bed. [Staff] immediately reported it to the administrator. Later on, the shift [Staff] noticed that resident was in another female's room, [Staff] immediately went

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F 600	Continued From page 5	F 600		

over there to let resident know that he cannot be in another resident's room alone. [Staff] notified the administrator right away."

R1's behavior note dated 1/25/22, at 11:46 a.m. included "Patient has been behaving inappropriately to other female residents. This morning he was caught touching [R4's] her breasts by [certified nursing assistant and [housekeeper] in the 70s common area. Nurse talked to the resident about his behavior and notified that if this behavior continues he will be reported as he is taking advantage of the vulnerable old female residents. Resident was also told to stay 3 to 4 feets [sic] away from the other female residents and no more visiting with the female resident no matter where in the building. Will keep to monitor and update as needed."

During an observation and interview on 1/31/22, at 2:49 p.m. R1 sat in his wheelchair in his room and stated he was going home soon. R1 stated he was recently caught by the nurse rubbing R4's "boobs" and stated R4 liked it when he did that. R1 stated he had only touched R4's breasts once and had not touched any other residents. R1 denied touching other residents inappropriately. R1 indicated he shouldn't have done that because he knew it was against the law. R1 stated when staff had seen him touching R4, he was removed from the area, and staff were watching him really close now. R1 stated he was not to go into other female resident rooms and was no allowed to have female residents in his room.

During an interview on 2/1/22, at 8:10 a.m. police officer (PO)-1 stated he was the responding

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officer to a call he had received on 1/25/22 after the incident with R4. PO-1 stated he had interviewed the staff who were witnesses to R1 touching R4's breasts. PO-1 stated from his interviews from staff, staff had been aware of R1's behaviors and had been going on for quite some time. PO-1 stated staff reported he would probably not be able to interview R4 because she probably would not remember the event and she had emotional distress after the incident. PO-1 stated he did not interview R4 for those reasons and did not want to cause any further distress. PO-1 indicated he asked staff to talk to R1, however when PO-1 got to R1's room he was not there. PO-1 stated he had observed R1 down the hallway with 3 other female residents without staff supervision. PO-1 stated when staff approached R1 to remove him away from the women, R1 refused and directed them to call the police. PO-1 indicated that's when he approached R1 to make his police presence known. PO-1 stated R1 denied touching R4's breast and only touched her hand on 1/25/22 but had R1 told him he touched R4's breast on 1/22/22, and R1 Had told him R4 liked her breasts being touched.

Interviews were conducted on 1/31/22, at 11:47 a.m. with facility staff who had knowledge of R1's sexual behaviors and witnessed R1 inappropriately touching residents which included - Registered nurse (RN)-A stated she had worked on 1/22/22, however was not assigned to R1's hallway. RN-A stated when she looked down R1's hallway she observed R4 sitting in her wheelchair with R1's hand down R4's shirt; R1 was clearly grabbing R4's breasts. RN-A stated she ran down the hallway and told him to stop immediately. RN-A stated R4 did not display any behaviors and was not reactionary. RN-A stated she removed

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R4 and brought her up to the nurse's station, called the administrator who then called the director of nursing, and then the director of nursing (DON) called her to get report of the incident. RN-A indicated no further care plan interventions were implemented. RN-A stated DON had a conversation with R1 via phone and directed and informed him he could not touch other residents. Administrator and director of nursing confirmed they had received the call from RN-A and the allegation was not reported to the state agency nor was an investigation initiated because they had not received all the details that R1 had physically touched R4's breast, and at the time had thought R4 had the capacity to consent.

-Nursing assistant (NA)-A stated she was aware of R1's inappropriate behaviors towards residents and indicated it had been going on almost since R1 was admitted to the facility. NA-A stated a couple of months ago she had responded to R2's call light, R2 was lying in bed crying, R1 was rubbing her legs up and down her leg. NA-A indicated although it seemed R2 sought R1 out, R2 did not want R1 touching her at that time. NA-A stated another aide removed R1 from the room, NA-A stated with R2, was able to console her, R2 then called a family member who arrived at the facility about an hour later. NA-A stated she thought she had reported to the charge nurse at the time, however, could not recall who the nurse was. NA-A stated when R1 was out in common areas he would watch female staff and residents and would rub himself through his pants. NA-A stated it made her feel uncomfortable and would no provide cares to him by herself. NA-A stated on 1/25/22, she had witnessed R1 rubbing R4's left breast and heard R4 telling R1 to stop. NA-A stated she told R1 to stop, NA-A told him to stop

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and saw RN-B. DON and administrator stated that had not been aware of the incident that involved R2.

-RN-B stated on 1/25/22, he saw R1 walk up to R4 and asked her if she had any boyfriends that came to visit. RN-B stated he redirected R1 and told him to stay away. RN-B stated he then went into someone else's room and a few minutes later he came out, when I heard NA-A telling R1 to stop. RN-B stated they removed R1 and educated him on staying away from the ladies. RN-B stated the administrator was immediately notified. RN-B stated R1 returned to his room and came out again later, RN-B indicated he then observed R1 asking R5 if she had any boyfriends and if they came to visit while rubbing her thigh. RN-B indicated an awareness if the incident that involved R5 was reported to the administrator. RN-B indicated after the incident R1 was supposed to be directly supervised. RN-B stated it seemed as though R1 would seek out the most vulnerable residents and that R1 was masturbating out in public areas and not that his urinary catheter was bothersome because there was no irritation and was consistent with his behavior. Administrator stated the incident between R1 and R4 was immediately reported to the state agency and to the DON; and was not aware of the incident with R5. Director of nursing indicated she had received a call from the administrator pertaining to the incident that had occurred between R1 and R4. DON stated 1:1 supervision and behavior monitoring was implemented, physician was made aware, medication changes were ordered, a cognition test was completed for R1 along with revision to care plan interventions, and mood symptoms screener was completed for R4. In addition,

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involved families were contacted and notified, and social services started working on R1's discharge plan. DON also indicated the facility developed and provided immediate re-education to staff members on abuse prevention and reporting procedures. Administrator stated she also was provided direct education by her supervisor pertaining to capacity to consent and reporting procedures. DON and human resource director provided and verified staff were all educated on 1/26/21.

During an interview on 1/31/22, at 3:45 p.m. NA-B stated a familiarity of R1 and his behaviors. NA-B stated upon admission to the transitional care unit (TCU) R1 did not have any behaviors and recently had "gotten really bad" and sexually inappropriate behaviors such as rubbing female resident thighs, asking inappropriate questions, and touching himself, in addition to sexually harassing female aides had been happening for about two months. NA-B stated R1 was cognitively intact and knew what he was doing, stated she heard him on the telephone telling someone about what he was doing and how they liked it. NA-B stated he was going into demented female resident rooms while they laid in bed, pull up their night gown and touch their thigh or rub their arms and tell them he loved them. NA-B stated we [NAs] we would walk past rooms, find him doing these things, and remove him from their room. NA-B stated a while ago she had been walking past R3's room when she found R3 sitting up in bed talking to R1 while he massaged her thigh. NA-B stated she had redirected R1 out of R3's room and reminded him he was not supposed to be there. NA-B thought she had reported the incident to the nurse, however, could not recall who the nurse was but thought she

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remembered documenting a behavior note. NA-B stated R6 had also reported to her that R1 made her feel uncomfortable because he would touch her legs and could not recall if she had reported to the nurse. NA-B stated the incidents with R3 and R6 occurred prior to 1/25/22. NA-B indicated for a while there was a sign with instructions for R1 posted in the nurse's station that directed staff what R1 could and could not do. For a while he could not go into any female residents' rooms and he could not have female visitors in his room, however that changed to he could only go into cognitive females room without supervision. NA-B could not recall the dates of implementation of these interventions. NA-B stated up until the incident with R1, R1 had general supervision then and not the 1:1 supervision R1 was getting now.

During an interview on 1/31/22 at 4:15 p.m. administrator and DON stated an unawareness of the abuse allegations that involved R3 and R6 that happened prior to 1/25/22; there for a report was not made to the state agency, a thorough investigation was not implemented, and interventions were not implemented to prevent further abuse.

During an interview on 2/1/22 at 10:30 a.m. DON indicated when staff become aware of allegation of abuse, the administrator is supposed to be immediately notified, then administrator notifies her. DON stated once she is notified, she calls the nurse that reported to get the details, directs the staff of what assessments to complete, and the immediate interventions to implement. DON stated the nurse is supposed to complete the assessments and implements the interventions, monitors and documents the interventions for effectiveness; if the interventions are not

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effective, then the nurse was supposed to call her back. DON stated had staff followed the appropriate reporting procedures, assessments, and appropriate interventions would have been correctly completed and implemented at the time of occurrence.

R4
R4's admission MDS dated 1/5/22 identified diagnosis of bipolar disorder and indicated R4 did not have cognitive impairment. The MDS identified R4 required extensive assistance from one staff for bed mobility and locomotion on and off the unit, two or more staff for transfers, and extensive assistance from one staff for dressing.

During an interview on 2/1/22, at 8:45 a.m. R4 laid in her bed. R4 stated an awareness of who R1 was. R4 stated, "He touched my breasts and it seemed he liked it." R4 stated she did no like R1 touching her and told him to stop. When asked how many different times R1 had touched her, R4 stated R1 had touched her several times. When R4 was asked if staff helped her when she was being touched, R4 lowered her head and did not respond.

R2
R2's quarterly MDS dated 12/24/21, indicated R2 did not have cognitive impairment, identified primary medical condition category as progressive neurological. The MDS also identified R2 required limited assistance from staff for transfers, did not walk, and one-person physical assistance for locomotion on and off the unit.

During an interview on 1/31/22, at 4:45 p.m. R2 stated a familiarity of R1 and his behaviors. R2 stated once he came into my room a while ago

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(R2 was unable to articulate a date), "I didn't have the tray table in front of me. R1 kept trying to touch my breast and I didn't want him to, he then tried to touch my crotch." R2 stated she kept trying to prevent him from touching her breast but couldn't totally prevent it. R2 waived her hands/arms in the air scissoring across her breasts (R2 demonstrated the motion) so he couldn't touch my breasts. R2 stated she did not want him to do that and felt violated. R2 stated staff came to help and removed R1 from her room. R2 indicated after the incident R1 continued to come into her room, however put the tray table across her chest to prevent R1 from touching her. R2 stated staff would notice R1 in her room and ask her if it was ok for him to be in there. R2 stated it was ok for him to be in her room as they were friends but did not want him touching her. R2 indicated staff would not stay in her room to supervise R1. R2 indicated R1 moved back down to the other hallway and had not been in her room lately.

R3
R3's quarterly MDS dated 1/7/22, identified R3 had diagnosis of non-Alzheimer's dementia and had moderate cognitive impairment. The MDS indicated R3 required supervision during transfers and walking, and for dressing required supervision after set-up.

During an interview on 1/31/21, at 4:40 p.m. R3 stated she was not aware of who R1 was and indicated she had not been inappropriately touched by staff or other residents.

R5
R5's quarterly MDS dated 12/10/21, identified R5 had diagnoses of schizophrenia, depression, and

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F 600	Continued From page 13 anxiety. The MDS indicated R5 had moderate cognitive impairment and required extensive assistance from two or more staff for bed mobility, extensive assist from one staff for transfers, dressing, and locomotion. R6 R6's quarterly MDS dated 12/3/21, identified R6 had diagnosis of non-Alzheimer's dementia, depression and had severe cognitive impairment. The MDS indicated R6 required one staff limited assistance for bed mobility, and extensive assistance from one staff for dressing. Facility policy Sexual Allegations Procedure dated 6/18/2019 included 1) The charge nurse of the unit where the alleged victim resides will verify that an allegation of criminal sexual conduct has been made. The charge nurse will then conduct an assessment of the alleged victim, initiate an Incident Report and immediately call the administrator and/or director of nursing to determine if 911 should be called. The charge nurse will ensure that no potential evidence is touched, so as to protect against contamination. 2) The charge nurse will take immediate steps appropriate to the situation to endure the protection and safety of the resident. 3) The administrator, director of nursing, or social worker will notify Minnesota Department of Health immediately. 6) The Nurse or Nurse manager will notify the physician and family regarding the facts of the situation. The immediate jeopardy that was removed on 1/26/22, after it was verified the facility completed the following actions before the abbreviated survey: -The allegation of abuse that occurred on 1/25/22	F 600		

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F 600	Continued From page 14 was reported timely in accordance with facility reporting procedures and the regulation. -The facility immediately reassessed R1 and put appropriate interventions in place that included 1:1 supervision in order to immediately protect residents and prevent reoccurrence until appropriate placement and discharge from the facility. -The facility provided re-education on abuse and reporting to procedures for direct care staff and ancillary staff. -The facility assessed staff knowledge by providing quizzes of the education and determined staff were competent. -The facility developed and implemented a monitoring system of the areas that had been identified as deficient.	F 600		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 610		3/7/22

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F 610	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure an investigation process that identified staff's failure to immediately report allegations of sexual abuse and identified the extent or pattern of sexual abuse allegations to ensure alleged victims did not require additional services or care plan changes for 4 of 4 residents (R2, R3, R5, and R6) reviewed for an allegation of sexual abuse. The facility's deficient practice has the potential to affect all current and future vulnerable female residents. Findings include A Facility Reported Incident (FRI) submitted to the State Agency on 1/25/22, alleged R1 inappropriately touched R4's breasts. The facility's investigative summary submitted to the SA on 1/29/22, identified a similar incident that had occurred between R1 and R4 on 1/22/22, however, did not identify additional sexual abuse allegations that involved R1 and other residents. The summary also identified corrective measures the facility took to protect other female residents that resided at the facility which included: contacted the police, moved R1 to a different unit, and placed R1 on 1:1 supervision. During facility staff interviews conducted 1/31/22, that pertained to reported allegations of sexual abuse that involved R1 and R4 resulted in findings of additional sexual abuse allegation for 4 other residents that the facility had not identified during their investigation. Interviews were conducted on 1/31/22, at 11:37	F 610	This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure an investigation process that identified staff's failure to immediately report allegations of sexual abuse and identified the extent or pattern of sexual abuse allegations to ensure alleged victims did not require additional services or care plan changes for 4 of 4 residents (R2, R3, R5, and R6) reviewed for an allegation of sexual abuse. The facility's deficient practice has the potential to affect all current and future vulnerable female residents When allegations of abuse related to R2, R3, R5 and R6 were brought to the director of nursing (DON) and administrator attention on 01/31/2022, these were immediately reported to the MN Department of Health on the Nursing Home Incident Reporting portal. After reporting the allegations, an investigation related to each allegation was initiated. The Social Services Department initially interviewed all cognitively intact residents and body audits were completed on all female residents to assess for signs of sexual maltreatment. R1 was placed on 15-minute checks on 01/25/2022 and moved off the long-term care unit to the transitional care unit and placed on a 1:1 starting 01/26/2022. Resident discharged from the facility on 02/01/2022.	

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F 610	Continued From page 16 a.m. with nursing assistant (NA)-A and registered nurse (RN)-B in the presence of administrator and director of nursing (DON). NA-A stated she was aware of R1's inappropriate behaviors towards residents and indicated it had been going on almost since R1 was admitted to the facility. NA-A stated a couple of months ago she had responded to R2's call light, R2 was lying in bed crying, R1 was rubbing her legs up and down. NA-A stated she thought she had reported to the charge nurse at the time, however, could not recall who the nurse was. RN-B indicated on 1/25/22, he had witnessed the incident between R1 and R4, shortly after that incident, he then observed R1 asking R5 if she had any boyfriends and if they came to visit while rubbing her thigh. RN-B indicated an awareness if the incident that involved R5 was reported to the administrator. Administrator and DON stated an unawareness of the incidents that involved R2 and R5 and they had not been reported. Administrator and DON indicated even though the facility investigation included interviews with staff and all cognizant residents no other allegations/incidents that involved sexual abuse and/or other incidents that involved R1 had been identified. During an interview on 1/31/22, at 3:45 p.m. NA-B stated a familiarity of R1 and his behaviors. NA-B stated upon admission to the transitional care unit (TCU) R1 did not have any behaviors and recently had "gotten really bad" and sexually inappropriate behaviors such as rubbing female resident thighs, asking inappropriate questions, and touching himself, in addition to sexually harassing female aides had been happening for about two months. NA-B stated he was going into demented female resident rooms while they laid in bed, pull up their night gown and touch their	F 610	The Social Services Department met with R2, R3, R5 and R6 on a weekly basis for four weeks to assess their psycho-social wellbeing. There were no concerns identified during this time. The facility started education with all staff on Abuse Prohibition/Vulnerable Adult identification and timely reporting on 01/25/2022, related to a similar incident with R1 and additional education was provided on 01/31/2022 and again at the All-Staff Meeting held on February 10, 2022. Monday through Friday, nursing leaders and social service staff review the 24-hour report (72-hour report on Monday's) looking for any documented signs of abuse or neglect and reported appropriately. The administrator and DON work collaboratively conducting thorough investigations of any alleged abuse and neglect. The DON and/or designee will interview a minimum of three staff per week on reporting requirements. The audits of the 24- or 72-hour report and staff interviews will continue for one month. The findings will be reviewed at the 03/22/2022 Quality Assurance and Performance Improvement (QAPI) meeting for further direction related to auditing and performance improvement.	

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thigh or rub their arms and tell them he loved them. NA-B stated we [NAs] would walk past rooms, find him doing these things, and remove him from their room. NA-B stated a while ago she had been walking past R3's room when she found R3 sitting up in bed talking to R1 while he massaged her thigh. NA-B thought she had reported the incident to the nurse, however, could not recall who the nurse was. NA-B stated R6 had also reported to her that R1 made her feel uncomfortable because he would touch her legs and could not recall if she had reported to the nurse. NA-B stated the incidents with R3 and R6 occurred prior to 1/25/22.

During an interview on 1/31/22 at 4:15 p.m. administrator and DON stated an unawareness of the abuse allegations that involved R3 and R6 that happened prior to 1/25/22. DON indicated allegations should have been reported in accordance with facility policy to ensure an allegation was thoroughly investigated at the time so appropriate interventions could be implemented.

During an interview on 1/31/21, at 4:40 p.m. R3 stated she was not aware of who R1 was and indicated she had not been inappropriately touched by staff or other residents.

During an interview on 1/31/22, at 4:45 p.m. R2 stated a familiarity of R1 and his behaviors. R2 stated once he came into her room a while ago (R2 was unable to articulate a date). R2 stated R1 kept trying to touch her breast and she didn't want him to, he then tried to touch her crotch." R2 stated she did not want him to do that and felt violated. R2 stated staff came to help and removed R1 from her room. R2 stated it was ok

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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) COMPLETION DATE
F 610	Continued From page 18 for him to be in her room as they were friends but did not want him touching her. R2 indicated R1 moved back down to the other hallway and had not been in her room lately. Facility policy Abuse Prohibition/Vulnerable Adult Plan dated 7/5/19, included Investigation/Protection: The investigation Team will review all incident reports regarding residents including those that indicate an injury of unknown origin, abuse, neglect, misappropriation of resident property or involuntary seclusion no later than the next working day following the incident. Investigations will begin immediately in accordance with Federal law. The Investigation Team will determine it further investigation is needed. the designated person will notify the designated agency in the state as soon as possible after reviewing the Vulnerable Adult Report. The investigation may include interviewing staff, residents, or other witnesses to the incident.	F 610		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		3/7/22

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F 758	Continued From page 19 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation. interview and document review the facility failed to identify and monitor for mood symptoms for antidepressant medications, failed to identify specific symptoms for off-labeled	F 758	This REQUIREMENT is not met as evidenced by: Based on observation. interview and document review the facility failed to identify and monitor for mood	

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F 758	Continued From page 20 use medications used to stabilize mood/behaviors, and failed to identify and monitor for specific target behaviors and individualized non-pharmacological interventions for antipsychotic medications for 1 of 2 residents (R2) reviewed for behaviors. Findings include R2's face sheet dated 2/3/22 included diagnoses of bipolar disorder and unspecified disorder of psychological development. R2's physician orders included the following psychoactive medications: -Seroquel (antipsychotic medication) 100 mg (milligrams) in the morning, at 3:00 p.m. and 200 mg at bedtime for bipolar disorder (start date 12/30/21) - Escitalopram Oxalate (antidepressant medication) 10 mg once daily for bipolar disorder (start date 12/30/21) -Oxcarbazepine (anticonvulsant medication) 150 mg twice daily for bipolar disorder (start date 12/30/21) -Depakote (anticonvulsant medication) 500 mg in the morning and 1000 mg at bedtime for bipolar disorder (12/30/21) -Buspirone (anxiolytic medication) 15 mg two times a day for bipolar disorder (start date 12/30/21) R2's admission Minimum Data Set (MDS) dated 1/5/22, indicated R2 did not have cognitive impairment, had delirium symptoms of inattention that fluctuated, had minimal depressive symptoms, and did not have verbal/physical behaviors. MDS identified R2 was administered antidepressant, antipsychotic of delirium did not have behaviors, and antianxiety medications.	F 758	symptoms for antidepressant medications, failed to identify specific symptoms for off-labeled use medications used to stabilize mood/behaviors, and failed to identify and monitor for specific target behaviors and individualized non-pharmacological interventions for antipsychotic medications for 1 of 2 residents (R2) reviewed for behaviors. R2 was prescribed an anti-depressant medication. Side effect monitoring was in place, a GAD-7 and PHQ-9 was done quarterly along with discussion at a quarterly psychotropic monitoring meeting that included, a licensed social worker (LSW), director of nursing (DON), nurse manager, medical director and a pharmacist. R2 discharged from the nursing facility to an assisted living facility in February 2022. The LSW and nursing staff are reviewing all residents on psychotropic medications and adding targeted behavior that are individualized. The targeted behaviors will be part of the psychotropic monitoring process related to dose adjustments or gradual dose reductions. The pharmacy consultant will also add this to the monthly chart reviews for all residents on psychotropic medications. DON and/or designee will conduct audits weekly, for residents on psychoactive medications, to ensure individualized behavior monitoring is in place and individualized. The information will be summarized at least quarterly for the	

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F 758	Continued From page 21 R2's psychotropic drug use Care Area Assessment (CAA) completed on 1/5/22, did not include an analysis of the medications, indicated the drug use would be in the care plan however lacked identification of the objective of the care plan was. The CAA did not identify the anticonvulsant medications ordered by the physician that identified the indication as "for bipolar disorder". The CAA also lacked identification of R2's behaviors and mood symptoms that the psychotropic medications were prescribed to treat/stabilize. The CAA included "Side effect monitoring is in place for these medications. Resident is short term rehab, and her mood has been stable. Plan to continue to monitor for medication side effects and monitor for changes in mood." R2's social services note on 1/5/22, indicated R2's assessments for anxiety and mood had been completed for the MDS. The note indicated R2 had feelings of nervousness several days, not being able to control her worries several days, and worrying about different things half of the days, and became easily annoyed several days. The note also indicated R2 had trouble falling asleep several days, feeling tired several days, having trouble concentrating several days, and felt she was moving slow several days. The assessment did not address R2 specific behaviors/mannerisms associated with the R2 anxiety and depressive symptoms. R2's care plan dated 1/5/22 did not identify the aforementioned assessment results. The care plan indicated R2 had the potential for psychotropic adverse drug reactions related to psychotropic medication, associated interventions	F 758	psychotropic monitoring meeting. The data collection will be done weekly and then presented at Quality Assurance and Performance Improvement (QAPI) meeting for further direction related to auditing and performance improvement.	

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F 758	Continued From page 22	F 758		

included Update MD/PA regarding effectiveness or adverse reactions. The care plan also included a focus of "Alteration in mood and behavior related to adjustment to new environment, change in routine, diagnoses of bipolar disorder, and obstructive sleep apnea." Associated interventions included, approach in a calm manner and provide resident with choices as able, provide emotional support, validation and comfort measures as needed. R2's care plan did not address specific mood symptoms and target behaviors that were associated with the non-descriptive nor specific interventions.

Review of R2's record reviewed from 12/30/21 through 1/26/22, The record lacked evidence of continuous behavior monitoring for antipsychotic medication or mood monitoring for the symptoms identified in the assessments completed on 1/5/22. In addition, the record lacked evidence non-pharmacological interventions were attempted or offered and lacked analysis of the effectiveness of medications.

R2's social services note dated 1/26/22 indicated R2 was assessed for mood and anxiety. The note indicated R2 was feeling down several days, having trouble falling asleep several days, feeling tired several days, had trouble concentrating several days, and felt as if she was moving slowly several days resident reported feeling nervous several days, worrying to much about different things several days, being restless several days, becoming easily annoyed several days, and feeling afraid something awful might happen several days. Resident reported that she worries most about her sister, and does not want anything bad to happen to her. Right now resident shows mild anxiety and depression indicated by

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F 758	Continued From page 23	F 758		

her scores. Resident offered no questions or concerns at this time. SS will continue to check in and be available as needed?

R2's records lacked revision of R2 behavioral care plan and did not identify the associated symptoms of anxiety/depression/restlessness R2 would display when she was worried, afraid, restless, annoyed, or worried. Furthermore, the record lacked non-pharmacological interventions to help manage the aforementioned symptoms. However, a physician order on 1/26/22, for behavior monitoring directed staff to monitor for a line listing of behavioral interventions for anxiety, depression, and psychosis that had not been identified in the 1/5 or the 1/26 assessments or the documentation in R2's record.

R2's corresponding Treatment Administration Record (TAR), indicated on 1/30/22 and 1/31/22, R2 had behaviors but number of occurrences was not identified. R2's corresponding progress note indicated R2 was confused and agitated she had slept through breakfast and lunch and was provided snacks and juice. The documentation did not identify if the interventions was effective. Progress note on 1/31/22 indicated R2 was confused, agitated, and yelling at staff thinking she had not eaten breakfast or lunch. The note indicated staff were able to redirect R2 however, the note did not identify what that re-direction was.

During an interview on 1/31/22, at 3:45 p.m. nursing assistant (NA)-B indicated behaviors were supposed to be identified on the care sheet, however, sometimes they were not. NA-B indicated if they noticed a behavior they would report the behavior to the nurses. NA-B indicated

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F 758	Continued From page 24 she had noticed there was not a lot of behavior documentation and thought it was because a lot of nurses were temporary agency. During an interview on 2/3/22, at 9:00 a.m. social services designee (SSD) and Licensed Social Worker (LSW) stated the interdisciplinary team met once a month for the psychotropic meeting in which they discussed any behaviors and the MDS's from the prior month. LSW indicated the group discussed if residents were having behaviors and if they need medication dose reductions. LSW stated there was not enough charting on resident behaviors to identify if the medication was effective or if the medication could be reduced. LSW indicated if the nurses were no documenting on behaviors and what type of behaviors the resident displayed they could not accurately complete the assessments and determine which interventions needed to be developed. A facility policy was not provided.	F 758		
F 839 SS=E	Staff Qualifications CFR(s): 483.70(f)(1)(2) §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 839	This REQUIREMENT is not met as	3/7/22

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F 839	Continued From page 25 facility failed to ensure 1 of 3 facility employed nursing assistance (NA-D) were currently certified within the State. Findings include According to the Minnesota Department of Health Nursing Assistant Registry Verification of Registration NA-A's certification expired on 10/15/2021. During an interview on 2/1/22, at 1:00 p.m. human resources director (HRD) confirmed NA-D's certification had expired and was not current on MDH nursing assistant registry. HRD indicated NA-D was hired on from the company's float pool, the expired recertification date was not identified during orientation to the facility and should have been. Facility policy Monarch Agency Policy for CNA's signed by NA-D on 10/14/21 included 1) A CNA pool employee a) Must be on the Nursing Assistant Registry in good standing to work as a CNA in Minnesota and/or Wisconsin.	F 839	evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 facility employed nursing assistance (NA-D) were currently certified within the State. NA-D was placed on leave until the nursing assistant certification was renewed. The facility will ensure staff members who provide care to residents are certified/licensed to do so upon hire. The Human Resource Director (HR) audited all employees to verify license and certifications were current. The HR Director has created a spreadsheet for all licensed staff and staff with certifications and has implemented a system to ensure renewals are done prior to expiration. The administrator and/or designee will audit the process and verify accuracy for a minimum of three employees weekly for four weeks and then monthly thereafter. The audit data will be presented to the Quality Assurance and Performance Improvement (QAPI) meeting for further direction related to auditing and performance improvement.	

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/31/22 to 2/3/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5067097C (MN00080583) with a licensing order issued at tag identification 0800. The following complaint was found to be SUBSTANTIATED: H5067096C (MN00080467 and MN00080526), with a licensing order was issued at tag identification 1540. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the	2 000		

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2 000	Continued From page 2 heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 facility employed nursing assistance (NA-D) were currently certified within the State. Findings include According to the Minnesota Department of Health Nursing Assistant Registry Verification of Registration NA-A's certification expired on	2 800	This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 facility employed nursing assistance (NA-D) were currently certified within the State. NA-D was placed on leave until the nursing assistant certification was renewed.	3/7/22

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2 800	Continued From page 3 10/15/2021. During an interview on 2/1/22, at 1:00 p.m. human resources director (HRD) confirmed NA-D's certification had expired and was not current on MDH nursing assistant registry. HRD indicated NA-D was hired on from the company's float pool, the expired recertification date was not identified during orientation to the facility and should have been. Facility policy Monarch Agency Policy for CNA's signed by NA-D on 10/14/21 included 1) A CNA pool employee a) Must be on the Nursing Assistant Registry in good standing to work as a CNA in Minnesota and/or Wisconsin. SUGGESTED METHOD OF CORRECTION: The administrator, DON or designee should ensure adequate policy and programs are developed to ensure licensed staff have the appropriate current licensure's and/or certifications for employment. The facility should educate staff on these policies and perform audits on staff records to ensure staff maintain current licensure/certification and are current on the State Registry or Board. The facility should report the findings of these audits to the quality assurance performance improvement (QAPI) committee for further recommendations to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800	The facility will ensure staff members who provide care to residents are certified/licensed to do so upon hire. The Human Resource Director (HR) audited all employees to verify license and certifications were current. The HR Director has created a spreadsheet for all licensed staff and staff with certifications and has implemented a system to ensure renewals are done prior to expiration. The administrator and/or designee will audit the process and verify accuracy for a minimum of three employees weekly for four weeks and then monthly thereafter. The audit data will be presented to the Quality Assurance and Performance Improvement (QAPI) meeting for further direction related to auditing and performance improvement.	
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring	21540		3/7/22

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21540	Continued From page 4 Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation. interview and document review the facility failed to identify and monitor for mood symptoms for antidepressant medications, failed to identify specific symptoms for off-labeled use medications used to stabilize mood/behaviors, and failed to identify and monitor for specific target behaviors and individualized non-pharmacological interventions for antipsychotic medications for 1 of 2 residents (R2) reviewed for behaviors. Findings include R2's face sheet dated 2/3/22 included diagnoses	21540	This REQUIREMENT is not met as evidenced by: Based on observation. interview and document review the facility failed to identify and monitor for mood symptoms for antidepressant medications, failed to identify specific symptoms for off-labeled use medications used to stabilize mood/behaviors, and failed to identify and monitor for specific target behaviors and individualized non-pharmacological interventions for antipsychotic medications for 1 of 2 residents (R2) reviewed for behaviors.	

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	00571	A. BUILDING: _____ B. WING _____	C 02/03/2022

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21540	Continued From page 5 of bipolar disorder and unspecified disorder of psychological development. R2's physician orders included the following psychoactive medications: -Seroquel (antipsychotic medication) 100 mg (milligrams) in the morning, at 3:00 p.m. and 200 mg at bedtime for bipolar disorder (start date 12/30/21) - Escitalopram Oxalate (antidepressant medication) 10 mg once daily for bipolar disorder (start date 12/30/21) -Oxcarbazepine (anticonvulsant medication) 150 mg twice daily for bipolar disorder (start date 12/30/21) -Depakote (anticonvulsant medication) 500 mg in the morning and 1000 mg at bedtime for bipolar disorder (12/30/21) -Buspirone (anxiolytic medication) 15 mg two times a day for bipolar disorder (start date 12/30/21) R2's admission Minimum Data Set (MDS) dated 1/5/22, indicated R2 did not have cognitive impairment, had delirium symptoms of inattention that fluctuated, had minimal depressive symptoms, and did not have verbal/physical behaviors. MDS identified R2 was administered antidepressant, antipsychotic of delirium did not have behaviors, and antianxiety medications. R2's psychotropic drug use Care Area Assessment (CAA) completed on 1/5/22, did not include an analysis of the medications, indicated the drug use would be in the care plan however lacked identification of the objective of the care plan was. The CAA did not identify the anticonvulsant medications ordered by the physician that identified the indication as "for bipolar disorder". The CAA also lacked identification of R2's behaviors and mood	21540	R2 was prescribed an anti-depressant medication. Side effect monitoring was in place, a GAD-7 and PHQ-9 was done quarterly along with discussion at a quarterly psychotropic monitoring meeting that included, a licensed social worker (LSW), director of nursing (DON), nurse manager, medical director and a pharmacist. R2 discharged from the nursing facility to an assisted living facility in February 2022. The LSW and nursing staff are reviewing all residents on psychotropic medications and adding targeted behavior that are individualized. The targeted behaviors will be part of the psychotropic monitoring process related to dose adjustments or gradual dose reductions. The pharmacy consultant will also add this to the monthly chart reviews for all residents on psychotropic medications. DON and/or designee will conduct audits weekly, for residents on psychoactive medications, to ensure individualized behavior monitoring is in place and individualized. The information will be summarized at least quarterly for the psychotropic monitoring meeting. The data collection will be done weekly and then presented at Quality Assurance and Performance Improvement (QAPI) meeting for further direction related to auditing and performance improvement.	

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21540	Continued From page 6	21540		

symptoms that the psychotropic medications were prescribed to treat/stabilize. The CAA included "Side effect monitoring is in place for these medications. Resident is short term rehab, and her mood has been stable. Plan to continue to monitor for medication side effects and monitor for changes in mood."

R2's social services note on 1/5/22, indicated R2's assessments for anxiety and mood had been completed for the MDS. The note indicated R2 had feelings of nervousness several days, not being able to control her worries several days, and worrying about different things half of the days, and became easily annoyed several days. The note also indicated R2 had trouble falling asleep several days, feeling tired several days, having trouble concentrating several days, and felt she was moving slow several days. The assessment did not address R2 specific behaviors/mannerisms associated with the R2 anxiety and depressive symptoms.

R2's care plan dated 1/5/22 did not identify the aforementioned assessment results. The care plan indicated R2 had the potential for psychotropic adverse drug reactions related to psychotropic medication, associated interventions included Update MD/PA regarding effectiveness or adverse reactions. The care plan also included a focus of "Alteration in mood and behavior related to adjustment to new environment, change in routine, diagnoses of bipolar disorder, and obstructive sleep apnea." Associated interventions included, approach in a calm manner and provide resident with choices as able, provide emotional support, validation and comfort measures as needed. R2's care plan did not address specific mood symptoms and target behaviors that were associated with the

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21540	Continued From page 7 non-descriptive nor specific interventions. Review of R2's record reviewed from 12/30/21 through 1/26/22, The record lacked evidence of continuous behavior monitoring for antipsychotic medication or mood monitoring for the symptoms identified in the assessments completed on 1/5/22. In addition, the record lacked evidence non-pharmacological interventions were attempted or offered and lacked analysis of the effectiveness of medications. R2's social services note dated 1/26/22 indicated R2 was assessed for mood and anxiety. The note indicated R2 was feeling down several days, having trouble falling asleep several days, feeling tired several days, had trouble concentrating several days, and felt as if she was moving slowly several days resident reported feeling nervous several days, worrying to much about different things several days, being restless several days, becoming easily annoyed several days, and feeling afraid something awful might happen several days. Resident reported that she worries most about her sister, and does not want anything bad to happen to her. Right now resident shows mild anxiety and depression indicated by her scores. Resident offered no questions or concerns at this time. SS will continue to check in and be available as needed? R2's records lacked revision of R2 behavioral care plan and did not identify the associated symptoms of anxiety/depression/restlessness R2 would display when she was worried, afraid, restless, annoyed, or worried. Furthermore, the record lacked non-pharmacological interventions to help manage the aforementioned symptoms. However, a physician order on 1/26/22, for behavior monitoring directed staff to monitor for a	21540		

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21540	Continued From page 8 line listing of behavioral interventions for anxiety, depression, and psychosis that had not been identified in the 1/5 or the 1/26 assessments or the documentation in R2's record. R2's corresponding Treatment Administration Record (TAR), indicated on 1/30/22 and 1/31/22, R2 had behaviors but number of occurrences was not identified. R2's corresponding progress note indicated R2 was confused and agitated she had slept through breakfast and lunch and was provided snacks and juice. The documentation did not identify if the interventions was effective. Progress note on 1/31/22 indicated R2 was confused, agitated, and yelling at staff thinking she had not eaten breakfast or lunch. The note indicated staff were able to redirect R2 however, the note did not identify what that re-direction was. During an interview on 1/31/22, at 3:45 p.m. nursing assistant (NA)-B indicated behaviors were supposed to be identified on the care sheet, however, sometimes they were not. NA-B indicated if they noticed a behavior they would report the behavior to the nurses. NA-B indicated she had noticed there was not a lot of behavior documentation and thought it was because a lot of nurses were temporary agency. During an interview on 2/3/22, at 9:00 a.m. social services designee (SSD) and Licensed Social Worker (LSW) stated the interdisciplinary team met once a month for the psychotropic meeting in which they discussed any behaviors and the MDS's from the prior month. LSW indicated the group discussed if residents were having behaviors and if they need medication dose reductions. LSW stated there was not enough charting on resident behaviors to identify if the	21540		

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21540	Continued From page 9 medication was effective or if the medication could be reduced. LSW indicated if the nurses were no documenting on behaviors and what type of behaviors the resident displayed they could not accurately complete the assessments and determine which interventions needed to be developed. A facility policy was not provided. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21540		