P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
May 17, 2022

Administrator
Avera Granite Falls Care Center
250 Jordan Drive
Granite Falls, MN 56241

RE: CCN: 245243
Cycle Start Date: April 29, 2022

Dear Administrator:

On April 29, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by July 29, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 29, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

Electronically delivered
May 17, 2022

Administrator
Avera Granite Falls Care Center
250 Jordan Drive
Granite Falls, MN 56241

Re: State Nursing Home Licensing Orders
Event ID: GXT511

Dear Administrator:

The above facility was surveyed on April 25, 2022 through April 29, 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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

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

Please feel free to call me with any questions.

Sincerely,

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245243	A. BUILDING ______ B. WING ______	C 04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA GRANITE FALLS CARE CTR	250 JORDAN DRIVE GRANITE FALLS, MN 56241

(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 4/27/22 through 4/29/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5243017C (MN82967), with deficiencies cited at F600, F607, F609, and F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 600 SS=D	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-	F 600		6/2/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/24/2022

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

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F 600	Continued From page 1 §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 interview and document review, the facility failed to ensure 1 of 1 resident (R1) was free from abuse and mistreatment by 1 of 1 staff (licensed practical nurse (LPN)-A) and protected against potential futher abuse. Findings include: Review of the 4/23/22, at 12:49 p.m., report to the State Agency (SA), identified that same day at approximately 6:00 a.m., nursing assistant (NA)-A entered R1's room and observed licensed practical nurse (LPN)-A attempting to give R1 his oral medication. R1 stated he wanted a drink first and wanted to wait on the medication until he had that sip of water. NA-A left the room to obtain items to provide morning cares. When she returned a short time later, LPN-A was seen attempting to force R1's oral medication into his mouth. R1 was coughing, spit, and yelled "NO!". LPN-A told R1 to "stop being a child! You are an adult!" and advised R1 "not to spit" at her. LPN-A then turned to leave when R1 yelled, "Get out of my room!". NA-A offered R1 a drink of water and attempted to comfort him as he began crying. NA-A got R1 dressed at that time. After getting dressed by NA-A, R1 came out of his room and reported to RN-A that LPN-A had "shoved pills" into his mouth and he subsequently had coughed and choked as the pills reportedly "went all over his face". R1 reported LPN-A had done this 3 times previously, and he was "going to let it go", however, LPN-A reportedly threatened R1 he had "better keep quiet" or she would "make his life	F 600	On 4/23/2022, VA was reported to MDH for alleged abuse on R1 as indicated on the initial report by LPN A. Correction Action Plan was completed 4/25/2022, prior to going back on the floor. Education was provided at this time related to Resident Rights, Vulnerable Adult and Caregiver Boundaries. Resident R1 Care Plan has been updated, when LPN A will be accompanied by a CNA while working with R1. LPN A has completed CBL's, Abuse and Neglect and Care Giver Boundaries on Non-complaint residents completed on 5/24/2022. Additional education was assigned to LPN A to complete within 30 days. LPN A is meeting with DON weekly x 4 weeks and then Monthly x 1 year 6/01/2022. Licensed Staff was re-educated on Vulnerable Adult Abuse and Prevention Plan and Mandatory Reporting on 5/11/2022. All staff education completed on 6/02/2022. On 5/04/22, all licensed staff were uploaded onto the MDH Nursing Home reporting website, education was provided on 5/11/2022 on Binders at the Nursing Stations with Policies and Instructions on reporting. Facility will protect all residents in similar situations by continued education with employees about abuse prevention, interviewing residents with quality of life audits and reviewing with Resident Rights during resident council meetings and	

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F 600	Continued From page 2	F 600		

miserable". RN-A then noted she had called the director of nursing (DON).

Review of the 4/27/22, 5 day investigation report to the SA identified the facility investigation identified R1 was administered medication unsafely. There was found to be "inappropriate" verbal communication "which caused initial distress". No changes were made to the policy. In review of the events that same day on 4/25/22, the facility interviewed LPN-A who denied R1 had choked and took his pills without difficulty. LPN-A admitted to "inappropriate comments" after she was reminded the incident was witnessed. LPN-A was given a disciplinary warning. LPN-A agreed to the corrective action. The facility identified the DON would "check" weekly with the DON and monthly x 1 year. The investigation conclusion noted the facility felt LPN-A was "remorseful" and different "approaches" were discussed. LPN-A was "off the weekend and did not return until corrective action was in place". The facility noted they were "working with HR for additional supplemental education to benefit nurse". The facility noted mental abuse had occurred as res had some forgetfulness, but was lucid that morning when reporting the allegation to RN-A. There was no mention in the investigation the facility appropriately suspended LPN-A after they had determined psychosocial harm had occurred and LPN-A had not yet been re-educated. There was also no indication the facility interviewed other residents, LPN-A's co-workers, or resident's family to identify if this had occurred in any other resident care, nor did it address how R1 would be kept safe from further abuse by LPN-A.

R1's 1/19/22, quarterly Minimum Data Set (MDS) identified he had severe cognitive impairment and

educating families during Family Council. During resident interviews no findings of potential abuse suspected.

Definitions of types of abuse reviewed and discussion of examples of abuse and appropriate time frames with each event. It is the policy of this facility to assist those who, because of physical and mental disability or dependence on institutional services, are vulnerable to abuse or neglect: to provide safe services and living environments; and to require the reporting of suspected abuse or neglect of those we serve on going.

5/19/2022-Vulnerable Adult Report was discussed in QAPI which includes, Quality/Infection Control Nurse, DON, Administrator, Support Nurses, Case Manager, Environmental Services and Medical Director. It was determined that an ALL Staff meeting (In person) be competed along with the CBL training that is currently assigned and due 5/31/2022.
All staff meeting held June 2nd, 2022.
Review of Who is a Mandated Reporter and review of Vulnerable Adult and Mandatory Reporting policy.
Compliance Requirements: Initiated 5/23/2022
Resident Audits x 4 weeks, quality of life survey questions and then monthly on-going. Education provided during Resident Council meeting regarding Resident Rights
Staff Audits x 4 weeks with different departments regarding Mandated Reporting and Definitions. Monthly x 3

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F 600	Continued From page 3 had a history of hallucinations and delusions. He required extensive assistance of 1 staff person for bed mobility, transfers, locomotion on/off the unit, dressing, toileting and personal hygiene. R1 required supervision of 1 staff for eating. R1's diagnoses included hallucinations, dementia, and Parkinson's disease. R1's current, undated nurse aide care sheet identified he was not to eat in bed, he was on hourly checks due to wandering, and had behaviors identified as hallucinations, delusions, and elopement attempts. There was no indication staff were made aware of interventions to keep R1 safe from potential further abuse. R1's current, undated care plan identified he was noted to have some hallucinations of seeing bugs, bees flying, talking to himself, and obsessing about his medication. R1 was noted to be allergic to bee stings and had a past anaphylactic (life endangering complication) reaction to a bee sting. R1's "delusions" were related to untrue beliefs about his family, anxiety and anger directed toward his wife, and making repetitive noises. R1 had behaviors noted of withdrawing from care and activities, had conflict with staff, and conflict with family and friends. Staff were to redirect or help to resolve conflicts that R1 may have with family and/or staff when gets "fixated" on an issue. There was no mention how the facility was to keep R1 safe from future potential abuse. Observation and Interview on 4/27/22 at 2:34 p.m., with R1 about the incident identified he was "still upset" and "hurt" over the incident when LPN-A tried to "force" him to take his meds. R1 reported he had been lying flat in bed, and had	F 600	months and then quarterly on-going On-going Annual Education on Vulnerable Adult and Abuse Policy and Mandated Reporting	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA GRANITE FALLS CARE CTR	**250 JORDAN DRIVE GRANITE FALLS, MN 56241**

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F 600	Continued From page 4 told LPN-A he needed a drink of water, but she didn't give him one. LPN-A stood by his bed and tried to "force the spoon with the meds" in his mouth. R1 stated he "still had a sore throat" he felt caused by one of the pills sticking in his throat. R1 reported after LPN-A forced the medication in his mouth, he began coughing and choking and had spit the pills out "all over his face...they had even gotten into my eyes". R1 reported this was the "3rd time this had happened with this same nurse", but he hadn't wanted to say anything before. R1 didn't know the nurse's name, but she had told him she would "shove the pills down my throat" and had "yelled" at him. R1 repeated he was "upset" by the incident and it "really bothered" him. R1 reported he liked most of the staff and had not had any problems with any other staff giving him his medication. R1 showed no outward signs of intimidation or fear while speaking to the surveyor. Interview 4/28/22 at 8:57 a.m., with RN-A identified she had worked on Saturday 4/23/22 and arrived about 6:00 a.m. that morning when NA-A came out of R1's room and reported the incident to her approximately between 6:30 to 7:00 a.m.. RN-A listened to allegation by NA-A of LPN-A and responded to her that would need to be reported. Although NA-A "was upset over the incident", she continued to assist R1 with his morning cares, delaying reporting of the incident. After NA-A had advised RN-A of the abuse allegation, RN-A reported she continued to pass her morning medications and did not immediately report the allegation to the DON. A short time later while she was passing medication to other residents, R1 came out of his room and stated he wanted to talk with her. RN-A noted R1 was alert and oriented when he came to speak with her. He	F 600		

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F 600	Continued From page 5 repeated the events of the incident that corresponded with NA-A's recollection of the events. RN-A identified she had contacted the DON on her cell phone later at 8:33 a.m., left a message, and sent a follow-up email at 8:55 a.m.. RN-A was aware of the need to immediately report the incident and begin an investigation, but was unsure how to do so. RN-A reported the DON returned her call after the email was sent, and said she was coming to the facility and "would take care of it". RN-A had not called Law Enforcement as the DON had stated it was "not physical abuse, and there was no need to contact" Law Enforcement. RN-A felt there was no concern with R1's safety as LPN-A had already left the facility at the end of her shift between 7:00 a.m. to 7:30 a.m. that morning, and was not scheduled to return "until the next week". RN-A identified two additional residents R2 and R3 that had previously voiced concerns about LPN-A, but R2 had a history of fabrication, and R3 had a known dislike of LPN-A, so "nothing had come of the reports" previously. RN-A felt no need to begin the investigation or question other staff or residents as "all the staff that had worked the night shift had all left the facility". R1 had no history of refusing medication administration previously. R1 always drank water first prior to being administered medication. RN-A identified she had received previous education online on abuse, resident rights rights and reporting in annual training, which she thought had been completed in the fall of 2021. She received no additional re-education following the incident. RN-A reported a resident had the right to refuse any cares or treatments, and the fact that R1 had stated, "NO" when he was offered his medications was a refusal and the appropriate action should have been to stop and either	F 600		

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F 600	Continued From page 6	F 600		

returned later or request a different staff person to attempt to administer the meds.

Interview on 4/28/22 9:25 a.m., with LPN- A identified she had been working the night of 4/23/22 and had administered R1's 6:00 a.m. medications. LPN-A reported she would administer R1's medications by placing them on a spoon. R1 would then open his mouth and take his medications. LPN-A stated there were times when R1 would state "NO" that didn't want his medication or that he "couldn't swallow", however, he would eventually take his medication and not have any issues. At the time of the incident, LPN-A recalled R1 was lying in bed when she had entered the room. She had raised the head of his bed and stated "let's take your meds". LPN-A reported the medication was in a spoon with applesauce. When she had attempted to give R1 a drink of water, he replied "NO...NO, you are choking me!". R1 started spitting out his meds and LPN-A reported she told R1 "We are adults here...We don't spit.". LPN-A reported R1 had taken another drink of water, finished swallowing his meds without any difficulty, and she left the room. LPN-A denied forcing the spoon into his mouth. LPN-A stated she did not feel she "had done anything wrong". LPN-A reported NA-A was present in R1's room providing cares. She was not aware of any "issue" until she had been contacted by the DON later that same day on 4/23/22, and was informed there had been a complaint with R1. LPN-A reported she had been contacted and told to report to the DON's office on 4/25/22 in the afternoon as the DON needed to talk with her about the alleged abuse. A corrective action plan had been presented by the DON which included additional training, review of the facility abuse, and a review of resident rights

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AVERA GRANITE FALLS CARE CTR	250 JORDAN DRIVE GRANITE FALLS, MN 56241

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policies and procedures. She was to meet with the DON every 4 weeks for the next year. LPN-A had not completed and re-education as indicated in her corrective action. LPN-A had been informed this was her final warning and any additional infractions would result in termination. LPN-A continued to work her regular scheduled shifts and had not cared for R1 unless it was "unavoidable". LPN-A was told to have another staff member in attendance when she entered R1's room.

Review of the facility schedules identified LPN-A worked night shifts ending her shift the following morning she was scheduled. LPN was scheduled to work night shift 4/22/22, 4/25/22 through 4/29/22. There was no indication LPN-A had been removed from the schedule and suspended from work until after the facility had completed its investigation on 4/27/22, or after she could be re-educated per her corrective action. There was also no indication another nurse was scheduled to work with LPN-A or how the facility would have another nurse available to protect R1 from further abuse if LPN-A would need to provide care or services to R1 in the future.

Interview on 4/28/22 at 10:02 a.m., with NA-A identified she was working on 4/23/22 and had responded to R1's call light when LPN-A came into R1's room around 5:45 a.m.. NA-A reported LPN-A had walked up the the bed where R1 was lying flat on his back with a pillow under his head carrying a spoon containing medication. LPN-A held out the spoon to R1 who responded, "No, I need a drink". NA- A left the room to retrieve some items and returned approximately 2 to 3 minutes later and observed LPN-A shoving the spoon against R1's closed mouth. R1 continued

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to say "NO!" and LPN-A continued to attempt to shove the spoon into R1's mouth. LPN-A was successful and at that time, R1 began coughing and spitting the medication out. LPN-A stated, "Don't you spit at me!" then put the spoon of medication into R1's mouth once more. LPN-A then stated, "Stop acting like a child... you are an adult!" At that point, NA-A intervened by stepping between LPN-A and R1. NA-A asked R1 if he was ok. LPN-A then turned and as she was leaving the room, R1 yelled, "Get him out of my room!" to LPN-A. NA-A reported she had given R1 a drink of water and he began to cry and stated, he "didn't want to be a bother". NA-A identified she had completed providing R1's morning cares and transferred him into his wheelchair before she went to report the incident to RN-A approximately 1/2 hour later. NA-A stated she had not gone immediately to report the incident because R1 was upset and she did not feel she should leave him alone when he was "so upset". NA-A reported she had been interviewed by RN-A and also by the DON when she had arrived back at work later that day. NA-A stated she "definitely felt this was abuse" by LPN-A. R1 had refused medication until he had water, but LPN-A "would not listen to him". NA- A denied knowledge of any previous incidents of potential abuse involving LPN-A with R1 or any other residents. No changes were made to R1's care to prevent potential additional abuse she was aware of.

Interview on 4/28/22 at 5:20 p.m., with family member (FM)-A identified she was familiar with LPN-A due to living in the community and her mother had actually worked with LPN-A previously. She described LPN-A as, "a little rough", which she defined as she could be rude or abrupt. She reported at times R1 would make

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comments that LPN-A "didn't have patience", and liked to tell him what he had to do. FM-A stated R1 would also make rude comments when she was visiting and LPN-A walked past his room. FM-A identified there had been other times when R1 had refused to take his medication and staff had tried later. If he still refused then staff would record that he had done so. FM-A stated she didn't understand why the nurse had not tried to administer his medication later or let him refuse. FM-A stated R1 did not like it when LPN-A came into his room. He did not like her, but he had never expressed to FM-A he was afraid of LPN-A. FM-A reported she was not aware of other incidents involving LPN-A, but when the DON had contacted her, she had requested LPN-A not provide care for R1. The DON had reported due to LPN-A working the night shift and limited staff available, a 2nd staff person would be in attendance if providing care to R1. FM-A was satisfied with that intervention.

Interview on 4/28/22 at 2:47 p.m., with the DON identified she was notified of the incident by RN-A on 4/23/22 at 8:33 a.m.. A follow up email was received at 8:55 a.m.. The DON was out of town, therefore it was about 10:30 a.m. when she arrived at the facility and began the investigation. The DON gave no direction to RN-A to report or begin an investigation. The DON interviewed both RN-A and NA-A upon her arrival, but had not been able to connect with LPN-A until about 11:30 a.m. to 12:00 p.m. on 4/23/22. The DON reported when she had spoken with LPN-A she had denied any unusual incidents involving R1, and that R1 had taken his medications that morning. The DON reported LPN-A had admitted she had gone ahead and given R1 his meds, after he had said 'NO", but denied forcing him.

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F 600	Continued From page 10 All staff directly involved were requested to complete a written statement of the incident. During a follow-up interview with LPN-A on 4/25/22, LPN-A admitted to telling R1 to "stop acting like a child", and told him to not spit at her. LPN-A documented R1 had swallowed his medications without difficulty and she had not forced him to take them, but that he had opened his mouth. The DON had not interviewed other staff or residents to identify if they had also had allegations of abuse or misconduct against LPN-A. The DON agreed LPN-A had not received any retraining and no additions were added to R1's care plan to ensure his safety. The DON contacted both the administrator and the Human Resources department for direction on how she should proceed. She felt law enforcement was not needed to be notified. The DON felt LPN-A had no intent to harm R1, therefore she had not suspended LPN-A pending investigation because she was not scheduled to work until the night shift of 4/25/22. The DON identified facility policy directed management to put a corrective action plan in place. LPN-A was counseled by the DON and received corrective action on 4/25/22 at 2:00 p.m. The policies on abuse were reviewed and the DON reviewed appropriate bedside manner with LPN-A who verbalized understanding and acceptance. The DON confirmed no additional education or review of the facility policies had been provided to other staff, nor had additional staff or residents been interviewed to determine if there were additional areas of concern related to LPN-A or other staff members. The DON confirmed she had not immediately implemented any additional safety measures for R1 due to LPN-A had finished her shift and was no longer in the facility at the time she began her investigation. She agreed the SA should have	F 600		

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F 600	Continued From page 11 been notified of the allegation immediately but no later than 2 hours, and a comprehensive investigation should have been conducted. She had spoken with LPN-A about having a 2nd person in attendance when entering R1's room when possible, but had not care planed or notified on duty staff of this intervention. There was no indication LPN-A had been reported to the MN Board of Nursing as required. Review of the July 2021, Vulnerable Adult Abuse Prevention Plan policy defined abuse as the willful infliction of injury with resulting physical harm, pain or mental anguish. All alleged violations involving abuse are to be reported immediately, but not later than 2 hours after the allegation is made. The facility was to develop an individual abuse prevention plan for each vulnerable adult residing in the facility or receiving services from the facility that includes specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. The facility must ensure that all alleged violations involving mistreatment or abuse are reported immediately to the administrator of the facility, and to other officials in accordance with State law. The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. Review of the November 2021, Patient/Resident Rights and Responsibilities policy identified a resident or their representative has the right to make informed decisions regarding the their care and treatment and has the right to refuse care and/or treatment. The patient/resident has the right to be treated with dignity, compassion and respect.	F 600		

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F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to to follow facility policy by immediately suspending 1 of 1 staff (licensed practical nurse (LPN)-A) pending the completion of an investigation of allegations of physical and verbal abuse toward 1 of 1 residents (R1), ensure all corrective actions were implemented prior to LPN-A returning to work, and implement protective measures to prevent future verbal abuse of R1. Findings include: Review of the 4/23/22, at 12:49 p.m., report to the State Agency (SA), identified that same day at approximately 6:00 a.m., nursing assistant (NA)-A entered R1's room and observed licensed practical nurse (LPN)-A attempting to give R1 his oral medication. R1 stated he wanted a drink first and wanted to wait on the medication until he had that sip of water. NA-A left the room to obtain items to provide morning cares. When she returned a short time later, LPN-A was seen	F 607	CFR(s) 483.12 Training: LPN A was assigned additional CBL training including Vulnerable Adult reporting and Care Giver Boundaries and How to manage Non-compliance. LPN A is currently on a Corrective Action Plan as of 4/25/2022 which included review of Vulnerable Adult Reporting, Mandatory Reporting and Resident Rights. LPN A was directed not to enter R1 room without another employee in attendance. Care plan has been updated and staff have been educated regarding entrance into Resident 1's room. Weekly Audits completed regarding behavior and practices x 4 weeks and then monthly x one year with LPN 1. Additional CBL's were assigned to LPN A and was completed on 5/24/2022. 5/11/2022-Licensed Staff Meeting- Review of Vulnerable Adult Reporting Policy and Mandatory Reporting. Education provided to Licensed Staff: What to do if there is an	6/2/22

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attempting to force R1's oral medication into his mouth. R1 was coughing, spit, and yelled "NO!". LPN-A told R1 to "stop being a child! You are an adult!" and advised R1 "not to spit" at her. LPN-A then turned to leave when R1 yelled, "Get out of my room!". NA-A offered R1 a drink of water and attempted to comfort him as he began crying. NA-A got R1 dressed at that time. After getting dressed by NA-A, R1 came out of his room and reported to RN-A that LPN-A had "shoved pills" into his mouth and he subsequently had coughed and choked as the pills reportedly "went all over his face". R1 reported LPN-A had done this 3 times previously, and he was "going to let it go", however, LPN-A reportedly threatened R1 he had "better keep quiet" or she would "make his life miserable". RN-A then noted she had called the director of nursing (DON).

Review of the 4/27/22, 5 day investigation report to the SA identified the facility investigation identified R1 was administered medication unsafely. There was found to be "inappropriate" verbal communication "which caused initial distress". No changes were made to the policy. In review of the events that same day on 4/25/22, the facility interviewed LPN-A who denied R1 had choked and took his pills without difficulty. LPN-A admitted to "inappropriate comments" after she was reminded the incident was witnessed. LPN-A was given a disciplinary warning. LPN-A agreed to the corrective action. The facility identified the DON would "check" weekly with the DON and monthly x 1 year. The investigation conclusion noted the facility felt LPN-A was "remorseful" and different "approaches" were discussed. LPN-A was "off the weekend and did not return until corrective action was in place". The facility noted they were "working with HR for additional

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alleged allegation regarding abuse to a resident, how to keep the resident safe and how to keep other residents safe within the facility.
Resident interviews implemented 5/23/2022 utilizing Quality of Life Survey tool. Staff education provided on how to recognize potential abuse at All Staff meeting, review of the Vulnerable Abuse prevention plan on 6/02/2022.
Audits to be reviewed in QAPI continued compliance.

PROCESS:
1.Remove the alleged individual from the facility until further investigation.
2.Notify the DON and the Administrator
3.File Vulnerable Report according to the appropriate time frames.
4.Is this a reportable crime, notify correct agencies (County, Law Enforcement)
5.Interview other residents who could potentially have been a victim as well.
6.Interview staff on resident behavior□s, mood, etc., that the alleged may have come in contact with or could have been affected by. Witness statements developed for Abuse issues.
7.Corrective Action Plan, additional training, increased monitoring or possible termination.
8. Complete all education prior to returning back to work.
9. Notify correct Licensing Board

Policy and Procedure updated to reflect above processes 5/23/2022-Information Placed in Binders at the Nurses station on both Neighborhood A and Neighborhood B

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F 607	Continued From page 14 supplemental education to benefit nurse". The facility noted mental abuse had occurred as res had some forgetfulness, but was lucid that morning when reporting the allegation to RN-A. There was no mention in the investigation the facility appropriately suspended LPN-A after they had determined psychosocial harm had occurred and LPN-A had not yet been re-educated. There was also no indication the facility interviewed other residents, LPN-A's co-workers, or resident's family to identify if this had occurred in any other resident care, nor did it address how R1 would be kept safe from further abuse by LPN-A. R1's 1/19/22, quarterly Minimum Data Set (MDS) identified he had severe cognitive impairment and had a history of hallucinations and delusions. He required extensive assistance of 1 staff person for bed mobility, transfers, locomotion on/off the unit, dressing, toileting and personal hygiene. R1 required supervision of 1 staff for eating. R1's diagnoses included hallucinations, dementia, and Parkinson's disease. R1's current, undated nurse aide care sheet identified he was not to eat in bed, he was on hourly checks due to wandering, and had behaviors identified as hallucinations, delusions, and elopement attempts. There was no indication staff were made aware of interventions to keep R1 safe from potential further abuse. R1's current, undated care plan identified he was noted to have some hallucinations of seeing bugs, bees flying, talking to himself, and obsessing about his medication. R1 was noted to be allergic to bee stings and had a past anaphylactic (life endangering complication) reaction to a bee sting. R1's "delusions" were	F 607	Per Lorie Tjaden, DON	

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related to untrue beliefs about his family, anxiety and anger directed toward his wife, and making repetitive noises. R1 had behaviors noted of withdrawing from care and activities, had conflict with staff, and conflict with family and friends. Staff were to redirect or help to resolve conflicts that R1 may have with family and/or staff when gets "fixated" on an issue. There was no mention how the facility was to keep R1 safe from future potential abuse.

Observation and Interview on 4/27/22 at 2:34 p.m., with R1 about the incident identified he was "still upset" and "hurt" over the incident when LPN-A tried to "force" him to take his meds. R1 reported he had been lying flat in bed, and had told LPN-A he needed a drink of water, but she didn't give him one. LPN-A stood by his bed and tried to "force the spoon with the meds" in his mouth. R1 stated he "still had a sore throat" he felt caused by one of the pills sticking in his throat. R1 reported after LPN-A forced the medication in his mouth, he began coughing and choking and had spit the pills out "all over his face...they had even gotten into my eyes". R1 reported this was the "3rd time this had happened with this same nurse", but he hadn't wanted to say anything before. R1 didn't know the nurse's name, but she had told him she would "shove the pills down my throat" and had "yelled" at him. R1 repeated he was "upset" by the incident and it "really bothered" him. R1 reported he liked most of the staff and had not had any problems with any other staff giving him his medication. R1 showed no outward signs of intimidation or fear while speaking to the surveyor.

Interview 4/28/22 at 8:57 a.m., with RN-A identified she had worked on Saturday 4/23/22

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F 607	Continued From page 16 and arrived about 6:00 a.m. that morning when NA-A came out of R1's room and reported the incident to her approximately between 6:30 to 7:00 a.m.. RN-A listened to allegation by NA-A of LPN-A and responded to her that would need to be reported. Although NA-A "was upset over the incident", she continued to assist R1 with his morning cares, delaying reporting of the incident. After NA-A had advised RN-A of the abuse allegation, RN-A reported she continued to pass her morning medications and did not immediately report the allegation to the DON. A short time later while she was passing medication to other residents, R1 came out of his room and stated he wanted to talk with her. RN-A noted R1 was alert and oriented when he came to speak with her. He repeated the events of the incident that corresponded with NA-A's recollection of the events. RN-A identified she had contacted the DON on her cell phone later at 8:33 a.m., left a message, and sent a follow-up email at 8:55 a.m.. RN-A was aware of the need to immediately report the incident and begin an investigation, but was unsure how to do so. RN-A reported the DON returned her call after the email was sent, and said she was coming to the facility and "would take care of it". RN-A had not called Law Enforcement as the DON had stated it was "not physical abuse, and there was no need to contact" Law Enforcement. RN-A felt there was no concern with R1's safety as LPN-A had already left the facility at the end of her shift between 7:00 a.m. to 7:30 a.m. that morning, and was not scheduled to return "until the next week". RN-A identified two additional residents R2 and R3 that had previously voiced concerns about LPN-A, but R2 had a history of fabrication, and R3 had a known dislike of LPN-A, so "nothing had come of the reports" previously. RN-A felt no	F 607		

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F 607	Continued From page 17 need to begin the investigation or question other staff or residents as "all the staff that had worked the night shift had all left the facility". R1 had no history of refusing medication administration previously. R1 always drank water first prior to being administered medication. RN-A identified she had received previous education online on abuse, resident rights rights and reporting in annual training, which she thought had been completed in the fall of 2021. She received no additional re-education following the incident. RN-A reported a resident had the right to refuse any cares or treatments, and the fact that R1 had stated, "NO" when he was offered his medications was a refusal and the appropriate action should have been to stop and either returned later or request a different staff person to attempt to administer the meds. Interview on 4/28/22 9:25 a.m., with LPN- A identified she had been working the night of 4/23/22 and had administered R1's 6:00 a.m. medications. LPN-A reported she would administer R1's medications by placing them on a spoon. R1 would then open his mouth and take his medications. LPN-A stated there were times when R1 would state "NO" that didn't want his medication or that he "couldn't swallow", however, he would eventually take his medication and not have any issues. At the time of the incident, LPN-A recalled R1 was lying in bed when she had entered the room. She had raised the head of his bed and stated "let's take your meds". LPN-A reported the medication was in a spoon with applesauce. When she had attempted to give R1 a drink of water, he replied "NO...NO, you are choking me!". R1 started spitting out his meds and LPN-A reported she told R1 "We are adults here...We don't spit.". LPN-A reported R1 had	F 607		

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	245243	A. BUILDING ______ B. WING ______	C 04/29/2022

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F 607	Continued From page 18 taken another drink of water, finished swallowing his meds without any difficulty, and she left the room. LPN-A denied forcing the spoon into his mouth. LPN-A stated she did not feel she "had done anything wrong". LPN-A reported NA-A was present in R1's room providing cares. She was not aware of any "issue" until she had been contacted by the DON later that same day on 4/23/22, and was informed there had been a complaint with R1. LPN-A reported she had been contacted and told to report to the DON's office on 4/25/22 in the afternoon as the DON needed to talk with her about the alleged abuse. A corrective action plan had been presented by the DON which included additional training, review of the facility abuse, and a review of resident rights policies and procedures. She was to meet with the DON every 4 weeks for the next year. LPN-A had not completed and re-education as indicated in her corrective action. LPN-A had been informed this was her final warning and any additional infractions would result in termination. LPN-A continued to work her regular scheduled shifts and had not cared for R1 unless it was "unavoidable". LPN-A was told to have another staff member in attendance when she entered R1's room. Review of the facility schedules identified LPN-A worked night shifts ending her shift the following morning she was scheduled. LPN was scheduled to work night shift 4/22/22, 4/25/22 through 4/29/22. There was no indication LPN-A had been removed from the schedule and suspended from work until after the facility had completed its investigation on 4/27/22, or after she could be re-educated per her corrective action. There was also no indication another nurse was scheduled to work with LPN-A or how the facility would have	F 607		

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F 607	Continued From page 19 another nurse available to protect R1 from further abuse if LPN-A would need to provide care or services to R1 in the future. Interview on 4/28/22 at 10:02 a.m., with NA-A identified she was working on 4/23/22 and had responded to R1's call light when LPN-A came into R1's room around 5:45 a.m.. NA-A reported LPN-A had walked up the the bed where R1 was lying flat on his back with a pillow under his head carrying a spoon containing medication. LPN-A held out the spoon to R1 who responded, "No, I need a drink". NA- A left the room to retrieve some items and returned approximately 2 to 3 minutes later and observed LPN-A shoving the spoon against R1's closed mouth. R1 continued to say "NO!" and LPN-A continued to attempt to shove the spoon into R1's mouth. LPN-A was successful and at that time, R1 began coughing and spitting the medication out. LPN-A stated, "Don't you spit at me!" then put the spoon of medication into R1's mouth once more. LPN-A then stated, "Stop acting like a child... you are an adult!" At that point, NA-A intervened by stepping between LPN-A and R1. NA-A asked R1 if he was ok. LPN-A then turned and as she was leaving the room, R1 yelled, "Get him out of my room!" to LPN-A. NA-A reported she had given R1 a drink of water and he began to cry and stated, he "didn't want to be a bother". NA-A identified she had completed providing R1's morning cares and transferred him into his wheelchair before she went to report the incident to RN-A approximately 1/2 hour later. NA-A stated she had not gone immediately to report the incident because R1 was upset and she did not feel she should leave him alone when he was "so upset". NA-A reported she had been interviewed by RN-A and also by the DON when she had arrived back at work later	F 607		

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F 607 Continued From page 20 F 607

that day. NA-A stated she "definitely felt this was abuse" by LPN-A. R1 had refused medication until he had water, but LPN-A "would not listen to him". NA- A denied knowledge of any previous incidents of potential abuse involving LPN-A with R1 or any other residents. No changes were made to R1's care to prevent potential additional abuse she was aware of.

Interview on 4/28/22 at 5:20 p.m., with family member (FM)-A identified she was familiar with LPN-A due to living in the community and her mother had actually worked with LPN-A previously. She described LPN-A as, "a little rough", which she defined as she could be rude or abrupt. She reported at times R1 would make comments that LPN-A "didn't have patience", and liked to tell him what he had to do. FM-A stated R1 would also make rude comments when she was visiting and LPN-A walked past his room. FM-A identified there had been other times when R1 had refused to take his medication and staff had tried later. If he still refused then staff would record that he had done so. FM-A stated she didn't understand why the nurse had not tried to administer his medication later or let him refuse. FM-A stated R1 did not like it when LPN-A came into his room. He did not like her, but he had never expressed to FM-A he was afraid of LPN-A. FM-A reported she was not aware of other incidents involving LPN-A, but when the DON had contacted her, she had requested LPN-A not provide care for R1. The DON had reported due to LPN-A working the night shift and limited staff available, a 2nd staff person would be in attendance if providing care to R1. FM-A was satisfied with that intervention.

Interview on 4/28/22 at 2:47 p.m., with the DON

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F 607	Continued From page 21 identified she was notified of the incident by RN-A on 4/23/22 at 8:33 a.m.. A follow up email was received at 8:55 a.m.. The DON was out of town, therefore it was about 10:30 a.m. when she arrived at the facility and began the investigation. The DON gave no direction to RN-A to report or begin an investigation. The DON interviewed both RN-A and NA-A upon her arrival, but had not been able to connect with LPN-A until about 11:30 a.m. to 12:00 p.m. on 4/23/22. The DON reported when she had spoken with LPN-A she had denied any unusual incidents involving R1, and that R1 had taken his medications that morning. The DON reported LPN-A had admitted she had gone ahead and given R1 his meds, after he had said 'NO", but denied forcing him. All staff directly involved were requested to complete a written statement of the incident. During a follow-up interview with LPN-A on 4/25/22, LPN-A admitted to telling R1 to "stop acting like a child", and told him to not spit at her. LPN-A documented R1 had swallowed his medications without difficulty and she had not forced him to take them, but that he had opened his mouth. The DON had not interviewed other staff or residents to identify if they had also had allegations of abuse or misconduct against LPN-A. The DON agreed LPN-A had not received any retraining and no additions were added to R1's care plan to ensure his safety. The DON contacted both the administrator and the Human Resources department for direction on how she should proceed. She felt law enforcement was not needed to be notified. The DON felt LPN-A had no intent to harm R1, therefore she had not suspended LPN-A pending investigation because she was not scheduled to work until the night shift of 4/25/22. The DON identified facility policy directed management to put a corrective action	F 607		

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F 607	Continued From page 22	F 607		

plan in place. LPN-A was counseled by the DON and received corrective action on 4/25/22 at 2:00 p.m. The policies on abuse were reviewed and the DON reviewed appropriate bedside manner with LPN-A who verbalized understanding and acceptance. The DON confirmed no additional education or review of the facility policies had been provided to other staff, nor had additional staff or residents been interviewed to determine if there were additional areas of concern related to LPN-A or other staff members. The DON confirmed she had not immediately implemented any additional safety measures for R1 due to LPN-A had finished her shift and was no longer in the facility at the time she began her investigation. She agreed the SA should have been notified of the allegation immediately but no later than 2 hours, and a comprehensive investigation should have been conducted. She had spoken with LPN-A about having a 2nd person in attendance when entering R1's room when possible, but had not care planed or notified on duty staff of this intervention. There was no indication LPN-A had been reported to the MN Board of Nursing as required.

Review of the July 2021, Vulnerable Adult Abuse Prevention Plan policy defined abuse as the willful infliction of injury with resulting physical harm, pain or mental anguish. All alleged violations involving abuse are to be reported immediately, but not later than 2 hours after the allegation is made. The facility was to develop an individual abuse prevention plan for each vulnerable adult residing in the facility or receiving services from the facility that includes specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. The facility must ensure that all alleged violations

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F 607	Continued From page 23 involving mistreatment or abuse are reported immediately to the administrator of the facility, and to other officials in accordance with State law. The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. Review of the November 2021, Patient/Resident Rights and Responsibilities policy identified a resident or their representative has the right to make informed decisions regarding the their care and treatment and has the right to refuse care and/or treatment. The patient/resident has the right to be treated with dignity, compassion and respect.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established	F 609		6/2/22

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F 609	Continued From page 24 procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the administrative staff and State Agency(SA) were notified within 2 hours of an allegation of physical and verbal abuse for 1 of 1 residents (R1) who was forced to take oral medications by a staff member. Review of the 4/23/22, at 12:49 p.m., report to the State Agency (SA), identified that same day at approximately 6:00 a.m., nursing assistant (NA)-A entered R1's room and observed licensed practical nurse (LPN)-A attempting to give R1 his oral medication. R1 stated he wanted a drink first and wanted to wait on the medication until he had that sip of water. NA-A left the room to obtain items to provide morning cares. When she returned a short time later, LPN-A was seen attempting to force R1's oral medication into his mouth. R1 was coughing, spit, and yelled "NO!". LPN-A told R1 to "stop being a child! You are an adult!" and advised R1 "not to spit" at her. LPN-A then turned to leave when R1 yelled, "Get out of my room!". NA-A offered R1 a drink of water and attempted to comfort him as he began crying. NA-A got R1 dressed at that time. After getting dressed by NA-A, R1 came out of his room and reported to RN-A that LPN-A had "shoved pills"	F 609	On 5/04/22, all licensed staff were uploaded onto the MDH Nursing Home reporting website, education was provided on 5/11/2022 on Policy Vulnerable Adult Reporting and Mandatory Reporting. Verbiage in policies was updated to reflect: Licensed staff was educated on 5/11/2022 on reporting time lines for alleged abuse to the MDH > 2 Hour time frame-abuse or serious bodily injury, Policy updated 5/11/2022 > 24 Hour time frame- if the alleged violation does not involve abuse or serious bodily harm Staff Weekly Audits x 4 weeks, then monthly on-going to review Mandated Reporting Staff will understand and be able to identify abuse and know the process of reporting ongoing Audits will be brought to QAPI and reviewed monthly. Notify appropriate Licensing Board	

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F 609	Continued From page 25 into his mouth and he subsequently had coughed and choked as the pills reportedly "went all over his face". R1 reported LPN-A had done this 3 times previously, and he was "going to let it go", however, LPN-A reportedly threatened R1 he had "better keep quiet" or she would "make his life miserable". RN-A then noted she had called the director of nursing (DON). Review of the 4/27/22, 5 day investigation report to the SA identified the facility investigation identified R1 was administered medication unsafely. There was found to be "inappropriate" verbal communication "which caused initial distress". No changes were made to the policy. In review of the events that same day on 4/25/22, the facility interviewed LPN-A who denied R1 had choked and took his pills without difficulty. LPN-A admitted to "inappropriate comments" after she was reminded the incident was witnessed. LPN-A was given a disciplinary warning. LPN-A agreed to the corrective action. The facility identified the DON would "check" weekly with the DON and monthly x 1 year. The investigation conclusion noted the facility felt LPN-A was "remorseful" and different "approaches" were discussed. LPN-A was "off the weekend and did not return until corrective action was in place". The facility noted they were "working with HR for additional supplemental education to benefit nurse". The facility noted mental abuse had occurred as res had some forgetfulness, but was lucid that morning when reporting the allegation to RN-A. There was no mention in the investigation the facility appropriately suspended LPN-A after they had determined psychosocial harm had occurred and LPN-A had not yet been re-educated. There was also no indication the facility interviewed other residents, LPN-A's co-workers, or resident's	F 609	Per Lorie Tjaden RN DON	

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F 609	Continued From page 26	F 609		

family to identify if this had occurred in any other resident care, nor did it address how R1 would be kept safe from further abuse by LPN-A. There was no indication staff were re-educated to reporting allegations of abuse immediately to the administrator, SA, and law enforcement.

R1's 1/19/22, quarterly Minimum Data Set (MDS) identified he had severe cognitive impairment and had a history of hallucinations and delusions. He required extensive assistance of 1 staff person for bed mobility, transfers, locomotion on/off the unit, dressing, toileting and personal hygiene. R1 required supervision of 1 staff for eating. R1's diagnoses included hallucinations, dementia, and Parkinson's disease.

Interview 4/28/22 at 8:57 a.m., with RN-A identified she had worked on Saturday 4/23/22 and arrived about 6:00 a.m. that morning when NA-A came out of R1's room and reported the incident to her approximately between 6:30 to 7:00 a.m.. RN-A listened to allegation by NA-A of LPN-A and responded to her that would need to be reported. Although NA-A "was upset over the incident", she continued to assist R1 with his morning cares, delaying reporting of the incident. After NA-A had advised RN-A of the abuse allegation, RN-A reported she continued to pass her morning medications and did not immediately report the allegation to the DON. A short time later while she was passing medication to other residents, R1 came out of his room and stated he wanted to talk with her. RN-A noted R1 was alert and oriented when he came to speak with her. He repeated the events of the incident that corresponded with NA-A's recollection of the events. RN-A identified she had contacted the DON on her cell phone later at 8:33 a.m., left a

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message, and sent a follow-up email at 8:55 a.m.. RN-A was aware of the need to immediately report the incident and begin an investigation, but was unsure how to do so. RN-A reported the DON returned her call after the email was sent, and said she was coming to the facility and "would take care of it". RN-A had not called Law Enforcement as the DON had stated it was "not physical abuse, and there was no need. RN-A felt there was no concern with R1's safety as LPN-A had already left the facility at the end of her shift between 7:00 a.m. to 7:30 a.m. that morning, and was not scheduled to return "until the next week".

Interview on 4/28/22 at 10:02 a.m., with NA-A identified she was working on 4/23/22 and had responded to R1's call light when LPN-A came into R1's room around 5:45 a.m.. NA-A reported LPN-A had walked up the the bed where R1 was lying flat on his back with a pillow under his head carrying a spoon containing medication. LPN-A held out the spoon to R1 who responded, "No, I need a drink". NA- A left the room to retrieve some items and returned approximately 2 to 3 minutes later and observed LPN-A shoving the spoon against R1's closed mouth. R1 continued to say "NO!" and LPN-A continued to attempt to shove the spoon into R1's mouth. LPN-A was successful and at that time, R1 began coughing and spitting the medication out. LPN-A stated, "Don't you spit at me!" then put the spoon of medication into R1's mouth once more. LPN-A then stated, "Stop acting like a child... you are an adult!" At that point, NA-A intervened by stepping between LPN-A and R1. NA-A asked R1 if he was ok. LPN-A then turned and as she was leaving the room, R1 yelled, "Get him out of my room!" to LPN-A. NA-A reported she had given R1 a drink of water and he began to cry and stated, he

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F 609	Continued From page 28 "didn't want to be a bother". NA-A identified she had completed providing R1's morning cares and transferred him into his wheelchair before she went to report the incident to RN-A approximately 1/2 hour later. NA-A stated she had not gone immediately to report the incident because R1 was upset and she did not feel she should leave him alone when he was "so upset". Interview on 4/28/22 at 2:47 p.m., with the DON identified she was notified of the incident by RN-A on 4/23/22 at 8:33 a.m.. A follow up email was received at 8:55 a.m.. The DON was out of town, therefore it was about 10:30 a.m. when she arrived at the facility and began the investigation. The DON gave no direction to RN-A to report or begin an investigation. The DON interviewed both RN-A and NA-A upon her arrival, but had not been able to connect with LPN-A until about 11:30 a.m. to 12:00 p.m. on 4/23/22. The DON confirmed no additional education or review of the facility policies had been provided to staff. She agreed the SA and law enforcement should have been notified of the allegation immediately but no later than 2 hours. There was no indication LPN-A had been reported to the MN Board of Nursing as required. Review of the July 2021, Vulnerable Adult Abuse Prevention Plan policy defined abuse as the willful infliction of injury with resulting physical harm, pain or mental anguish. All alleged violations involving abuse are to be reported immediately, but not later than 2 hours after the allegation is made.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		6/2/22

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F 610	Continued From page 29 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate 1 of 1 allegation of abuse and mistreatment for 1 of 1 residents (R1), ensured R1 was protected from further potential abuse, and ensure corrective action was implemented prior to staff returning to work. Findings include: Review of the 4/23/22, at 12:49 p.m., report to the State Agency (SA), identified that same day at approximately 6:00 a.m., nursing assistant (NA)-A entered R1's room and observed licensed practical nurse (LPN)-A attempting to give R1 his oral medication. R1 stated he wanted a drink first and wanted to wait on the medication until he had that sip of water. NA-A left the room to obtain items to provide morning cares. When she	F 610	LPN A has completed Vulnerable Adult Reporting and Care Giver Boundaries and How to manage non-compliance. Education was provided to staff on 5/11/2022 regarding processes of Abuse Allegations. Processes have been updated and added to the Mandatory Reporting Policy. Immediate removal of the alleged perpetrator, notification of the Administrator and Director of Nursing, Filing the Vulnerable Adult report to OFHC within the appropriate time frame and notifying Law Enforcement or County Agency if this a reportable crime. Ensure other residents are safe, interview staff and residents that could be potentially affected. Witness statements have been developed 5/23/2022 to help with the interview process and determine	

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F 610	Continued From page 30 returned a short time later, LPN-A was seen attempting to force R1's oral medication into his mouth. R1 was coughing, spit, and yelled "NO!". LPN-A told R1 to "stop being a child! You are an adult!" and advised R1 "not to spit" at her. LPN-A then turned to leave when R1 yelled, "Get out of my room!". NA-A offered R1 a drink of water and attempted to comfort him as he began crying. NA-A got R1 dressed at that time. After getting dressed by NA-A, R1 came out of his room and reported to RN-A that LPN-A had "shoved pills" into his mouth and he subsequently had coughed and choked as the pills reportedly "went all over his face". R1 reported LPN-A had done this 3 times previously, and he was "going to let it go", however, LPN-A reportedly threatened R1 he had "better keep quiet" or she would "make his life miserable". RN-A then noted she had called the director of nursing (DON). Review of the 4/27/22, 5 day investigation report to the SA identified the facility investigation identified R1 was administered medication unsafely. There was found to be "inappropriate" verbal communication "which caused initial distress". No changes were made to the policy. In review of the events that same day on 4/25/22, the facility interviewed LPN-A who denied R1 had choked and took his pills without difficulty. LPN-A admitted to "inappropriate comments" after she was reminded the incident was witnessed. LPN-A was given a disciplinary warning. LPN-A agreed to the corrective action. The facility identified the DON would "check" weekly with the DON and monthly x 1 year. The investigation conclusion noted the facility felt LPN-A was "remorseful" and different "approaches" were discussed. LPN-A was "off the weekend and did not return until corrective action was in place". The facility noted	F 610	suspected abuse allegations to be true or false. These reports will be used as a part of the investigation and reported to OHFC within in 5 days of initial report. Notify appropriate Licensing Board of suspected abuse. The Avera Granite Falls Abuse Prevention Plan consists of the following 7 components: 1. Prevention 2. Screening 3. Identification 4. Training 5. Protection 6. Investigation 7. Reporting/response All Staff Meeting Discussion: Vulnerable Adult Reporting Avera Granite Falls will maintain a proactive approach to identify events that may contribute to abuse and/or neglect. Risk factors will be identified within our population including disease process, mental and physical disabilities of those we serve, staffing factors to include scheduling practices, turnover rates, absenteeism and quality of work life. Training provided to employees on dealing with appropriate interventions for aggressive or challenging behaviors, how to report incidents or allegations without fear of reprisal and recognizing stress and frustrations that may lead to potential abuse. Process and Vulnerable Adult Prevention Plan discussed in QAPI 5/19/2022 Audits reviewed in QAPI for continued compliance.	

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they were "working with HR for additional supplemental education to benefit nurse". The facility noted mental abuse had occurred as res had some forgetfulness, but was lucid that morning when reporting the allegation to RN-A. There was no mention in the investigation the facility appropriately suspended LPN-A after they had determined psychosocial harm had occurred and LPN-A had not yet been re-educated. There was also no indication the facility interviewed other residents, LPN-A's co-workers, or resident's family to identify if this had occurred in any other resident care, nor did it address how R1 would be kept safe from further abuse by LPN-A.

R1's 1/19/22, quarterly Minimum Data Set (MDS) identified he had severe cognitive impairment and had a history of hallucinations and delusions. He required extensive assistance of 1 staff person for bed mobility, transfers, locomotion on/off the unit, dressing, toileting and personal hygiene. R1 required supervision of 1 staff for eating. R1's diagnoses included hallucinations, dementia, and Parkinson's disease.

R1's current, undated nurse aide care sheet identified he was not to eat in bed, he was on hourly checks due to wandering, and had behaviors identified as hallucinations, delusions, and elopement attempts. There was no indication staff were made aware of interventions to keep R1 safe from potential further abuse.

R1's current, undated care plan identified he was noted to have some hallucinations of seeing bugs, bees flying, talking to himself, and obsessing about his medication. R1 was noted to be allergic to bee stings and had a past anaphylactic (life endangering complication)

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reaction to a bee sting. R1's "delusions" were related to untrue beliefs about his family, anxiety and anger directed toward his wife, and making repetitive noises. R1 had behaviors noted of withdrawing from care and activities, had conflict with staff, and conflict with family and friends. Staff were to redirect or help to resolve conflicts that R1 may have with family and/or staff when gets "fixated" on an issue. There was no mention how the facility was to keep R1 safe from future potential abuse.

Observation and Interview on 4/27/22 at 2:34 p.m., with R1 about the incident identified he was "still upset" and "hurt" over the incident when LPN-A tried to "force" him to take his meds. R1 reported he had been lying flat in bed, and had told LPN-A he needed a drink of water, but she didn't give him one. LPN-A stood by his bed and tried to "force the spoon with the meds" in his mouth. R1 stated he "still had a sore throat" he felt caused by one of the pills sticking in his throat. R1 reported after LPN-A forced the medication in his mouth, he began coughing and choking and had spit the pills out "all over his face...they had even gotten into my eyes". R1 reported this was the "3rd time this had happened with this same nurse", but he hadn't wanted to say anything before. R1 didn't know the nurse's name, but she had told him she would "shove the pills down my throat" and had "yelled" at him. R1 repeated he was "upset" by the incident and it "really bothered" him. R1 reported he liked most of the staff and had not had any problems with any other staff giving him his medication. R1 showed no outward signs of intimidation or fear while speaking to the surveyor.

Interview 4/28/22 at 8:57 a.m., with RN-A

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F 610	Continued From page 33 identified she had worked on Saturday 4/23/22 and arrived about 6:00 a.m. that morning when NA-A came out of R1's room and reported the incident to her approximately between 6:30 to 7:00 a.m.. RN-A listened to allegation by NA-A of LPN-A and responded to her that would need to be reported. Although NA-A "was upset over the incident", she continued to assist R1 with his morning cares, delaying reporting of the incident. After NA-A had advised RN-A of the abuse allegation, RN-A reported she continued to pass her morning medications and did not immediately report the allegation to the DON. A short time later while she was passing medication to other residents, R1 came out of his room and stated he wanted to talk with her. RN-A noted R1 was alert and oriented when he came to speak with her. He repeated the events of the incident that corresponded with NA-A's recollection of the events. RN-A identified she had contacted the DON on her cell phone later at 8:33 a.m., left a message, and sent a follow-up email at 8:55 a.m.. RN-A was aware of the need to immediately report the incident and begin an investigation, but was unsure how to do so. RN-A reported the DON returned her call after the email was sent, and said she was coming to the facility and "would take care of it". RN-A had not called Law Enforcement as the DON had stated it was "not physical abuse, and there was no need to contact" Law Enforcement. RN-A felt there was no concern with R1's safety as LPN-A had already left the facility at the end of her shift between 7:00 a.m. to 7:30 a.m. that morning, and was not scheduled to return "until the next week". RN-A identified two additional residents R2 and R3 that had previously voiced concerns about LPN-A, but R2 had a history of fabrication, and R3 had a known dislike of LPN-A, so "nothing had	F 610		

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F 610 Continued From page 34 F 610

come of the reports" previously. RN-A felt no need to begin the investigation or question other staff or residents as "all the staff that had worked the night shift had all left the facility". R1 had no history of refusing medication administration previously. R1 always drank water first prior to being administered medication. RN-A identified she had received previous education online on abuse, resident rights rights and reporting in annual training, which she thought had been completed in the fall of 2021. She received no additional re-education following the incident. RN-A reported a resident had the right to refuse any cares or treatments, and the fact that R1 had stated, "NO" when he was offered his medications was a refusal and the appropriate action should have been to stop and either returned later or request a different staff person to attempt to administer the meds.

Interview on 4/28/22 9:25 a.m., with LPN- A identified she had been working the night of 4/23/22 and had administered R1's 6:00 a.m. medications. LPN-A reported she would administer R1's medications by placing them on a spoon. R1 would then open his mouth and take his medications. LPN-A stated there were times when R1 would state "NO" that didn't want his medication or that he "couldn't swallow", however, he would eventually take his medication and not have any issues. At the time of the incident, LPN-A recalled R1 was lying in bed when she had entered the room. She had raised the head of his bed and stated "let's take your meds". LPN-A reported the medication was in a spoon with applesauce. When she had attempted to give R1 a drink of water, he replied "NO...NO, you are choking me!". R1 started spitting out his meds and LPN-A reported she told R1 "We are adults

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here...We don't spit.". LPN-A reported R1 had taken another drink of water, finished swallowing his meds without any difficulty, and she left the room. LPN-A denied forcing the spoon into his mouth. LPN-A stated she did not feel she "had done anything wrong". LPN-A reported NA-A was present in R1's room providing cares. She was not aware of any "issue" until she had been contacted by the DON later that same day on 4/23/22, and was informed there had been a complaint with R1. LPN-A reported she had been contacted and told to report to the DON's office on 4/25/22 in the afternoon as the DON needed to talk with her about the alleged abuse. A corrective action plan had been presented by the DON which included additional training, review of the facility abuse, and a review of resident rights policies and procedures. She was to meet with the DON every 4 weeks for the next year. LPN-A had not completed and re-education as indicated in her corrective action. LPN-A had been informed this was her final warning and any additional infractions would result in termination. LPN-A continued to work her regular scheduled shifts and had not cared for R1 unless it was "unavoidable". LPN-A was told to have another staff member in attendance when she entered R1's room.

Review of the facility schedules identified LPN-A worked night shifts ending her shift the following morning she was scheduled. LPN was scheduled to work night shift 4/22/22, 4/25/22 through 4/29/22. There was no indication LPN-A had been removed from the schedule and suspended from work until after the facility had completed its investigation on 4/27/22, or after she could be re-educated per her corrective action. There was also no indication another nurse was scheduled

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F 610	Continued From page 36 to work with LPN-A or how the facility would have another nurse available to protect R1 from further abuse if LPN-A would need to provide care or services to R1 in the future. Interview on 4/28/22 at 10:02 a.m., with NA-A identified she was working on 4/23/22 and had responded to R1's call light when LPN-A came into R1's room around 5:45 a.m.. NA-A reported LPN-A had walked up the the bed where R1 was lying flat on his back with a pillow under his head carrying a spoon containing medication. LPN-A held out the spoon to R1 who responded, "No, I need a drink". NA- A left the room to retrieve some items and returned approximately 2 to 3 minutes later and observed LPN-A shoving the spoon against R1's closed mouth. R1 continued to say "NO!" and LPN-A continued to attempt to shove the spoon into R1's mouth. LPN-A was successful and at that time, R1 began coughing and spitting the medication out. LPN-A stated, "Don't you spit at me!" then put the spoon of medication into R1's mouth once more. LPN-A then stated, "Stop acting like a child... you are an adult!" At that point, NA-A intervened by stepping between LPN-A and R1. NA-A asked R1 if he was ok. LPN-A then turned and as she was leaving the room, R1 yelled, "Get him out of my room!" to LPN-A. NA-A reported she had given R1 a drink of water and he began to cry and stated, he "didn't want to be a bother". NA-A identified she had completed providing R1's morning cares and transferred him into his wheelchair before she went to report the incident to RN-A approximately 1/2 hour later. NA-A stated she had not gone immediately to report the incident because R1 was upset and she did not feel she should leave him alone when he was "so upset". NA-A reported she had been interviewed by RN-A and also by	F 610		

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the DON when she had arrived back at work later that day. NA-A stated she "definitely felt this was abuse" by LPN-A. R1 had refused medication until he had water, but LPN-A "would not listen to him". NA- A denied knowledge of any previous incidents of potential abuse involving LPN-A with R1 or any other residents. No changes were made to R1's care to prevent potential additional abuse she was aware of.

Interview on 4/28/22 at 5:20 p.m., with family member (FM)-A identified she was familiar with LPN-A due to living in the community and her mother had actually worked with LPN-A previously. She described LPN-A as, "a little rough", which she defined as she could be rude or abrupt. She reported at times R1 would make comments that LPN-A "didn't have patience", and liked to tell him what he had to do. FM-A stated R1 would also make rude comments when she was visiting and LPN-A walked past his room. FM-A identified there had been other times when R1 had refused to take his medication and staff had tried later. If he still refused then staff would record that he had done so. FM-A stated she didn't understand why the nurse had not tried to administer his medication later or let him refuse. FM-A stated R1 did not like it when LPN-A came into his room. He did not like her, but he had never expressed to FM-A he was afraid of LPN-A. FM-A reported she was not aware of other incidents involving LPN-A, but when the DON had contacted her, she had requested LPN-A not provide care for R1. The DON had reported due to LPN-A working the night shift and limited staff available, a 2nd staff person would be in attendance if providing care to R1. FM-A was satisfied with that intervention.

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F 610	Continued From page 38 Interview on 4/28/22 at 2:47 p.m., with the DON identified she was notified of the incident by RN-A on 4/23/22 at 8:33 a.m.. A follow up email was received at 8:55 a.m.. The DON was out of town, therefore it was about 10:30 a.m. when she arrived at the facility and began the investigation. The DON gave no direction to RN-A to report or begin an investigation. The DON interviewed both RN-A and NA-A upon her arrival, but had not been able to connect with LPN-A until about 11:30 a.m. to 12:00 p.m. on 4/23/22. The DON reported when she had spoken with LPN-A she had denied any unusual incidents involving R1, and that R1 had taken his medications that morning. The DON reported LPN-A had admitted she had gone ahead and given R1 his meds, after he had said 'NO", but denied forcing him. All staff directly involved were requested to complete a written statement of the incident. During a follow-up interview with LPN-A on 4/25/22, LPN-A admitted to telling R1 to "stop acting like a child", and told him to not spit at her. LPN-A documented R1 had swallowed his medications without difficulty and she had not forced him to take them, but that he had opened his mouth. The DON had not interviewed other staff or residents to identify if they had also had allegations of abuse or misconduct against LPN-A. The DON agreed LPN-A had not received any retraining and no additions were added to R1's care plan to ensure his safety. The DON contacted both the administrator and the Human Resources department for direction on how she should proceed. She felt law enforcement was not needed to be notified. The DON felt LPN-A had no intent to harm R1, therefore she had not suspended LPN-A pending investigation because she was not scheduled to work until the night shift of 4/25/22. The DON identified facility policy	F 610		

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F 610	Continued From page 39 directed management to put a corrective action plan in place. LPN-A was counseled by the DON and received corrective action on 4/25/22 at 2:00 p.m. The policies on abuse were reviewed and the DON reviewed appropriate bedside manner with LPN-A who verbalized understanding and acceptance. The DON confirmed no additional education or review of the facility policies had been provided to other staff, nor had additional staff or residents been interviewed to determine if there were additional areas of concern related to LPN-A or other staff members. The DON confirmed she had not immediately implemented any additional safety measures for R1 due to LPN-A had finished her shift and was no longer in the facility at the time she began her investigation. She agreed the SA should have been notified of the allegation immediately but no later than 2 hours, and a comprehensive investigation should have been conducted. She had spoken with LPN-A about having a 2nd person in attendance when entering R1's room when possible, but had not care planed or notified on duty staff of this intervention. There was no indication LPN-A had been reported to the MN Board of Nursing as required. Review of the July 2021, Vulnerable Adult Abuse Prevention Plan policy defined abuse as the willful infliction of injury with resulting physical harm, pain or mental anguish. All alleged violations involving abuse are to be reported immediately, but not later than 2 hours after the allegation is made. The facility was to develop an individual abuse prevention plan for each vulnerable adult residing in the facility or receiving services from the facility that includes specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245243	A. BUILDING ______ B. WING ______	C 04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA GRANITE FALLS CARE CTR	250 JORDAN DRIVE GRANITE FALLS, MN 56241

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F 610	Continued From page 40 The facility must ensure that all alleged violations involving mistreatment or abuse are reported immediately to the administrator of the facility, and to other officials in accordance with State law. The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. Review of the November 2021, Patient/Resident Rights and Responsibilities policy identified a resident or their representative has the right to make informed decisions regarding the their care and treatment and has the right to refuse care and/or treatment. The patient/resident has the right to be treated with dignity, compassion and respect.	F 610		