Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 24, 2024

Administrator
Thief River Care Center
2001 Eastwood Drive
Thief River Falls, MN 56701

RE: CCN: 245252
Cycle Start Date: April 12, 2023

Dear Administrator:

On April 12, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted 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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 12, 2024 (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 12, 2024 (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
Health Regulation Division
Telephone: (651) 201-4112
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
	245252	A. BUILDING _____ B. WING _____	C 04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

(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 4/11/24 through 4/12/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H52522901C (MN102232) H52523063C (MN100950) H52523062C (MN99789) As a result of the survey deficiencies were cited at F609, 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 609 SS=D	. Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(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	F 609		5/6/24

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

Electronically Signed | 05/01/2024

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 609	Continued From page 1 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 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 report an allegation of sexual assault to the state agency (SA) for 1 of 3 residents reviewed who alleged she had been raped at the facility. Findings include: R4's Resident Face Sheet identified diagnosis that included Parkinsonism, Alzheimer's disease and dementia. R4's significant change Minimum Data Set (MDS) dated 3/2/24, identified severe cognitive impairment and indicated physical and verbal behaviors. The MDS further indicated R4	F 609	In response to reporting of alleged violations, the facility must have evidence that all alleged violations are thoroughly investigated and reported. R4 had made claims that she was sexually assaulted. A thorough investigation was not found, nor reporting was found. An investigation was completed at the time of OFHC visit and found that R4 could not recollect the statements made. Resident made statements about having her head slammed into a wall. Exam completed and no injury found. Staff were interviewed. Interventions in place include investigation of any statement resident	

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F 609	Continued From page 2 displayed hallucinations and delusions. R4's care plan updated 4/9/24 identified auditory hallucinations exhibited by seeing people in room, yelling, hitting and refusal to take medications. The care plan indicated R4 voiced false accusations about staff. The care plan directed staff to provide one to one, offer food/drink, call spouse, turn on television and re-approach. R4's facility Progress Note dated 2/28/24 at 4:46 p.m., indicated R4 was upset and yelling and sated the guy with the square head, "ended up raping me." 2/28/24 at 10:40 p.m. R4 was noted at the hallway screaming and yelling that "he wants to rape me." 3/11/24, R4 had two episodes of delusional behavior with hallucinations. R4 accused male nursing assistant (NA) of raping her. R4 had accused male NA of rape before which was not substantiated. During interview on 4/10/24 at 2:42 p.m., the social services designee (SSD) indicated R4 was not "cognitively strong" and said she knew who she was and where she was and on a good day could tell you what day it was. The SSD stated, "I know she has accused people of raping her" but was not sure where it came from. The SSD stated she was not involved in the reporting process. During interview on 4/11/24 at 3:10 p.m. the director of nursing (DON) stated R4 had made accusations that staff were trying to practice voodoo on her and staff had smashed her head, and that staff had tried to beat her up. The DON stated R4 did say she had been raped and said staff had talked to her but R4 tended to be vague and did not provide a lot of detail. The DON	F 609	makes. Ongoing visit with psych ARNP and having 2 staff and no male staff care for resident. All residents have a right to report concerns regardless of cognitive status. DON or designee will look through incidents and progress notes daily to see if an investigation and or VA need to be completed. Staff were trained on filing incident reports and process for reporting incidents and potential VAs to the Administrator, DON, or designee. Maltreatment policies and procedures were reviewed with no changes made. DON or designee will do daily review of progress notes and incident reports. DON or designee will investigation/RCA audits 3x/week for 4 weeks, 2x/week for 4 weeks, and 1 x/week for 4 weeks with IDT. Findings will be brought to QAPI for further recommendations for ongoing monitoring.	

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F 609	Continued From page 3 stated registered nurse (RN)-A sat and talked with R4 and determined it was not a thing. During interview on 4/11/24 at 3:42 p.m. RN-B stated R4 had good times and tough times and said she had behaviors. RN-B stated when R4 tried to explain things she was unclear. RN-B stated she was aware R4 had made an allegation of rape and said she heard it during report in the past. During interview on 4/11/24 at 4:58 p.m., the administrator stated R4's allegations of rape had not been reported to the SA and said she had not been aware of the rape allegations. Facility policy Maltreatment Reporting Guidelines dated 10/8/21, indicated the facility must report to the SA any suspected maltreatment (all alleged violations involving abuse, neglect, exploitation or maltreatment, including injuries of unknown source and misappropriation of resident property) immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		5/6/24

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F 610	Continued From page 4 §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 investigation an allegation of sexual assault for 1 of 3 residents (R4) who alleged she was raped at the facility. Findings include: R4's significant change Minimum Data Set (MDS) dated 3/2/24, identified severe cognitive impairment and indicated physical and verbal behaviors. The MDS further indicated R4 displayed hallucinations and delusions. R4's care plan updated 4/9/24, identified auditory hallucinations exhibited by seeing people in room, yelling, hitting and refusal to take medications. The care plan indicated R4 voiced false accusations about staff. The care plan directed staff to provide one to one, offer food/drink, call spouse, turn on television and re-approach. R4's facility Progress Note dated 2/28/24 at 4:46 p.m., indicated R4 was upset and yelling and sated the guy with the square head, "ended up raping me." 2/28/24 at 10:40 p.m. R4 was noted at the hallway screaming and yelling that "he wants to rape me." 3/11/24, R4 had two episodes of delusional behavior with hallucinations. R4 accused male nursing assistant (NA) of raping	F 610	In response to allegations of abuse, neglect, exploitation, or mistreatment, that facility must have evidence that all alleged violations are thoroughly investigated and reported. R4 had made claims that she was sexually assaulted. A thorough investigation was not found. An investigation was completed at the time of OFHC visit and found that R4 could not recollect the statements made. Resident made statements about having her head slammed into a wall. Exam completed and no injury found. Staff were interviewed. Interventions in place include investigation of any statement resident makes. Ongoing visit with psych ARNP and having 2 staff and no male staff care for resident. All residents have a right to report concerns regardless of cognitive status. DON or designee will look through incidents and progress notes daily to see if an investigation and or VA need to be completed. Staff were trained on filing incident reports and process for reporting incidents and potential VAs to the Administrator, DON, or designee. Maltreatment policies and procedures	

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F 610	Continued From page 5 her. R4 had accused male NA of rape before which was not substantiated. During interview on 4/10/24 at 2:42 p.m., the social services designee (SSD) indicated R4 was not "cognitively strong" and said she knew who she was and where she was and on a good day could tell you what day it was. The SSD stated, "I know she has accused people of raping her" but was not sure where it came from. The SSD stated she was not involved in the reporting and investigation process. During interview on 4/11/24 at 3:10 p.m. the director of nursing (DON) stated R4 had made accusations that staff were trying to practice voodoo on her and staff had smashed her head, and that staff had tried to beat her up. The DON stated R4 did say she had been raped and said staff had talked to her but R4 tended to be vague and did not provide a lot of detail. The DON stated registered nurse (RN)-A sat and talked with R4 and determined it was not a thing. The DON stated she did not have evidence an investigation had been completed because they did not believe the rape had occurred. During interview on 4/11/24, at 4:58 p.m. the administrator said she had not been aware of the allegations. Facility Policy Maltreatment Reporting Guidelines dated 10/1/21, directed staff to begin conducting an investigation of the alleged maltreatment, which may include resident and staff interviews, observations and medical record review.	F 610	were reviewed and no changes were made/needed. DON or designee will do daily review of progress notes and incident reports. DON or designee will investigation/RCA audits 3x/week for 4 weeks, 2x/week for 4 weeks, and 1 x/week for 4 weeks with IDT. Findings will be brought to QAPI for further recommendations for ongoing monitoring.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 24, 2024

Administrator
Thief River Care Center
2001 Eastwood Drive
Thief River Falls, MN 56701

Re: State Nursing Home Licensing Orders
Event ID: E7G311

Dear Administrator:

The above facility was surveyed on April 11, 2024 through April 12, 2024 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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
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
	00448	A. BUILDING: _____ B. WING _____	C 04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/11/24 through 4/12/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed. H52522901C (MN102232) H52523063C (MN100950) H52523062C (MN99789) As a result of the survey a licensing order was issued at 1980. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor 's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00448	A. BUILDING: _____ B. WING _____	C 04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a	21980		5/6/24

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21980	Continued From page 3 reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to report an allegation of sexual assault to the state agency (SA) for 1 of 3 residents reviewed who alleged she had been raped at the facility. Findings include: R4's Resident Face Sheet identified diagnosis that included Parkinsonism, Alzheimer's disease and dementia. R4's significant change Minimum Data Set (MDS) dated 3/2/24, identified severe cognitive impairment and indicated physical and verbal behaviors. The MDS further indicated R4 displayed hallucinations and delusions.	21980	corrected	

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21980	Continued From page 4 R4's care plan updated 4/9/24 identified auditory hallucinations exhibited by seeing people in room, yelling, hitting and refusal to take medications. The care plan indicated R4 voiced false accusations about staff. The care plan directed staff to provide one to one, offer food/drink, call spouse, turn on television and re-approach. R4's facility Progress Note dated 2/28/24 at 4:46 p.m., indicated R4 was upset and yelling and sated the guy with the square head, "ended up raping me." 2/28/24 at 10:40 p.m. R4 was noted at the hallway screaming and yelling that "he wants to rape me." 3/11/24, R4 had two episodes of delusional behavior with hallucinations. R4 accused male nursing assistant (NA) of raping her. R4 had accused male NA of rape before which was not substantiated. During interview on 4/10/24 at 2:42 p.m., the social services designee (SSD) indicated R4 was not "cognitively strong" and said she knew who she was and where she was and on a good day could tell you what day it was. The SSD stated, "I know she has accused people of raping her" but was not sure where it came from. The SSD stated she was not involved in the reporting process. During interview on 4/11/24 at 3:10 p.m. the director of nursing (DON) stated R4 had made accusations that staff were trying to practice voodoo on her and staff had smashed her head, and that staff had tried to beat her up. The DON stated R4 did say she had been raped and said staff had talked to her but R4 tended to be vague and did not provide a lot of detail. The DON stated registered nurse (RN)-A sat and talked with R4 and determined it was not a thing.	21980		

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21980	Continued From page 5 During interview on 4/11/24 at 3:42 p.m. RN-B stated R4 had good times and tough times and said she had behaviors. RN-B stated when R4 tried to explain things she was unclear. RN-B stated she was aware R4 had made an allegation of rape and said she heard it during report in the past. During interview on 4/11/24 at 4:58 p.m., the administrator stated R4's allegations of rape had not been reported to the SA and said she had not been aware of the rape allegations. Facility policy Maltreatment Reporting Guidelines dated 10/8/21, indicated the facility must report to the SA any suspected maltreatment (all alleged violations involving abuse, neglect, exploitation or maltreatment, including injuries of unknown source and misappropriation of resident property) immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility could re-educate staff to policies and procedures, and audit all complaints of alleged abuse or neglect in a measurable and specific way. The results of those audits could be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. Those audits could be ongoing and random after compliance is determined by QAPI to ensure compliance is being maintained.	21980		

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21980	Continued From page 6 TIME PERIOD FOR CORRECTION: 21 DAYS	21980		