Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 1, 2024

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

RE: CCN: 245252
Cycle Start Date: April 12, 2024

Dear Administrator:

On April 24, 2024, we informed you that we may impose enforcement remedies.

On April 19, 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 immediate jeopardy (Level J), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other 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), whereby corrections were required.

REMOVAL OF IMMEDIATE JEOPARDY

On April 15, 2024, the situation of immediate jeopardy to potential

health and safety cited at F600 was removed.

REMEDIES

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

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 12, 2024

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 12, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 12, 2024.

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

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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

SUBSTANDARD QUALITY OF CARE (SQC)

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

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

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Thief River Care Center is prohibited from offering or conducting a Nurse Assistant Training

/ Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective April 15, 2024. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

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

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

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.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 12, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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

<u>Steven.Delich@cms.hhs.gov</u>

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at

(312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

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

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

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May 1, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: LNZO11

Dear Administrator:

The above facility was surveyed on April 17, 2024 through April 19, 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
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 04/19/2024

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	F 000		
	On 4/17/24 through 4/19/24, 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: H52523244C (MN102496) and a deficiency was issued at a PAST NON-COMPLIANCE IJ at F600. The immediate jeopardy (IJ) began on 4/13/24, at approximately 1:15 p.m. when R1 was left in the dining room unsupervised and found rubbing the genitals of a female resident (R2) who was unable to leave the area on her own. The IJ was identified on 4/19/24, and the director of nursing (DON) was notified of the IJ on 4/19/24, at 2:00 p.m. The immediate jeopardy was removed on 4/15/24, and the deficient practice was corrected prior to the start of the survey and was therefore issued at past noncompliance. As a result of the investigation, a deficiency was issued at F609. 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		Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 05/07/2024

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 000	Continued From page 1 regulations has been attained.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adequate supervision to prevent resident to resident sexual abuse when 1 of 2 resident (R1) who had a recent incident of resident-to-resident sexual abuse was found in the dining room rubbing a second female resident's (R2) genitals. This was an immediate jeopardy for R2 because this type of inappropriate and unwanted sexual contact would reasonably cause anyone to have psychosocial harm. It can be determined that the reasonable person in the resident's position would have experienced severe psychosocial harm including dehumanization and humiliation as a result of the sexual abuse. The immediate jeopardy (IJ) began on 4/13/24, at	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2	F 600		

approximately 1:15 p.m. when R1 was left in the dining room unsupervised and found rubbing the genitals of a female resident (R2) who was unable to leave the area on her own. The IJ was identified on 4/19/24, and the director of nursing (DON) was notified of the IJ on 4/19/24, at 2:00 p.m. The immediate jeopardy was removed on 4/15/24, and the deficient practice was corrected prior to the start of the survey and was therefore issued at past noncompliance.

Findings include:

R1's Resident Face Sheet, print date of 4/23/24, identified diagnosis that included Alzheimer's, dementia, anxiety and depression.

R1's quarterly Minimum Data Set (MDS) dated 1/4/24, identified severe cognitive impairment and indicated he required assistance with transfer and self-propelled in his wheelchair. R1's Service Plan Modification Report, undated, identified inappropriate actions and touching female residents. R1's service plan identified non-pharmacological interventions added 4/3/24, that included document whereabouts for patterns of behavior, redirection, engage in reading books and watch movies. 4/17/24, service plan was updated to include the addition of antipsychotic medications.

R1's nursing assistant care sheet undated, included monitor when out of room due to "touchy" with ladies, hourly checks, seat at dining table with other males and back toward crowd and not left alone in the dining room, when done eating move by nurse until all residents are out of the dining room. The care sheet further indicated during activities R1 would be placed by male

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F 600	Continued From page 3	F 600		

residents and with staff.

During observation on 4/17/24, at 4:37 p.m. R1 was escorted to the dining room by staff. R1 was seated facing the back wall of the dining room with another male resident. R1 remained in the dining room supervised by staff until 6:16 p.m. when all other residents had left the dining room.

R1's Progress Notes indicated the following:

3/29/24, Nursing assistant (NA) reported that she was going around getting residents from the unit down to the dining room before supper when she noted a call light and responded to the light. The NA went in to check the resident in that room and found R1 at the female resident's bedside in his wheel chair with his hands underneath the covers. R1 had his hands underneath her clothed buttocks. The NA assisted him in removing his hands from underneath the resident and brought him down to the dining room and reported to writer. The female resident in was in no distress and everything else in her room appeared untouched. R1 stated a few times as he was assisted to the dining room "I didn't hurt her". R1 was assisted to his meal, then stated " I just wanted to push my penis up against it to feel it."

4/7/24, R1 was seated in the chair in the corner of the room with only a shirt on. R1 stated he could get his penis up to belly button for writer. Writer assisted resident with putting brief, pants and socks on. While writer had resident standing, resident stated he could turn a little bit and slip it right in.

4/9/24 on 4/5/24 at a care conference, the administrator, DON, assistant director of nursing

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F 600	Continued From page 4	F 600		

(ADON), social worker & nurse manager reviewed the 3/29/24, incident and interventions with R1's family member (FM)-A. Reviewed all the non-pharmacological interventions in place, reviewed the incident, investigation findings, and new interventions in place. Provided education about medication recommendations, specifically to address sexual urges, and explained side effect monitoring protocols. FM-A was able to provide additional items for redirection. Activities staff have modified their invitation request language and R1 had responded well with increased participation.

4/13/24, NA reported to staff that R1 was rubbing the genital area of a female resident (R2). NA-A stated R1 had his left hand on R2's upper thigh and his right hand was rubbing back and forth on her genitalia. No nursing staff were in the dining room at the time of the incident. R2 later reported it made her feel uncomfortable. R1 was placed on 15 minute checks until further notice.

During observation on 4/17/24 at 4:43 p.m. R1 was seated in the dining room in his wheelchair facing the back wall of the dining room. R1 was seated with another male resident at the table. Outside the dining room a staff member was supervising from a large window.

R2's Resident Face Sheet print date of 4/23/24, identified diagnosis that included Hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), schizoaffective disorder, depression, anxiety and aphasia (disorder that results from damage to portions of the brain that are responsible for language).

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F 600	Continued From page 5	F 600		

R2's annual MDS dated 3/19/24, indicated a Brief Interview for Mental Status (BIMS) of 6 (severe cognitive impairment) and indicated she did not display behaviors. R2's Service Plan Modification Report indicated she preferred a stop sign to keep wanderers out of her room, added 4/4/24.

R2's Resident Progress Notes indicated the following:

-4/13/24, Call made to R2's FM (family member) to update her on the incident that occurred.

-4/15/24, R2 was asked about the events on 4/13/24, and stated "I was scared but I don't let him bother me. I'll yell again."

An untitled, undated facility investigation indicated 4/13/24, vulnerable adult report. The investigation indicated on call registered nurse (RN) notified DON that R1 was rubbing the clothed groin of R2 in the dining room just prior to the noon meal time. Staff report that they were following the care plan for R1 by having him in the dining room first and out last. Staff were transporting residents into the Blueberry dining room. When nursing assistant (NA) entered the dining room with another resident, NA saw R1 with his hand on R2's knee and the other hand on R2's groin, rubbing back and forth. The NA separated the two residents and transferred R2 to her room. The licensed practical nurse (LPN) on duty reported she implemented interventions of 15 minute checks on R1 and R1 would wait outside of dining room before and after meals until staff were able to sit with him in the dining room and take him back to the unit. Staff verified that care plan was being followed for R1 and that all stop signs were in place during the shift. Staff reported that they

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F 600		F 600		

Continued From page 6
were transferring residents back to unit area after meal and that no staff members were present in the dining room at the time of the incident. R1 was interviewed and could not recall event. R2 was interviewed and stated "I was scared but I don't let him [R1] bother me. I'll yell again." R2 was offered counseling.

Review of resident to resident Incident on 4/13/24 lacked evidence R1 was adequately supervised to protect other vulnerable residents in the dining room.

The Facility investigation outlined interventions that included: Hourly checks ongoing. R1 was moved to a table in the dining room with only males and not within sight of female residents. R1 will be placed outside the dining room by the nurse prior to start of meal and at the end of the meal while staff are transporting other residents back and forth to unit. During activities R1 will be stationed next to a staff member. Behavioral health physician met with care team to discuss R1. Medication management included the addition of antipsychotic medication. Protection for R2 included keeping her out of R1's sight line at meals and activities. Keep reasonable distance between R1 and R2. Ongoing use of mesh stop sign at room door. Protection for general population included changing dining room seating, R1 seated at table with other men and staff member in dining room when R1 was present in dining room.

During interview on 4/17/24 at 1:47 p.m., registered nurse (RN)-B stated prior to the incident on 4/13/24, stop signs had been placed on the doors of the more vulnerable residents. RN-B stated immediately following the incident on

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	245252	A. BUILDING ______ B. WING ______	C 04/19/2024

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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F 600	Continued From page 7	F 600		

4/13/24, R1 had been placed on 15 minute checks but had since transitioned to hourly checks ongoing.

During interview on 4/17/24 at 1:52 p.m., NA-B stated since the incident on 4/13/24, R1 had been placed on hourly checks. NA-B said R1 had to be the first one in the dining room and the last one out and could not be left alone and said if the NA's were busy he had to remain next to the nurse.

During interview on 4/17/24 at 2:02 p.m., licensed practical nurse (LPN)-A stated when R1 was in the dining room he had to sit facing away from other residents and had to be in sight of staff of all times. LPN-A said R1 had to be the first one in the dining room and the last out for supervision.

During interview on 4/17/24 at 2:08 p.m., NA-C stated when in the dining room, R1 sat with other males. NA-C said she had received communication both written and verbal. NA-C said R1's location in the dining room had been changed and staff were to sit with him.

During observation and interview on 4/17/24 at 7:27 p.m., R2 was in her wheelchair in her room watching television. R2 stated she remembered the incident from 4/13/24. When asked if she was afraid, R2 said "well, not afraid, I was trying to get away." R2 further stated no staff were in the dining room and that the incident had made her uncomfortable. Lastly, R2 indicated, "I just don't want to have him [R1] here."

During interview on 4/17/24 at 7:39 p.m., RN-C stated R1 has supposed to be the first one in the dining room and the last out and said some of the

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residents had stop signs on their doors to keep him from wandering in. RN-C said since the incident on 4/13/24, R1 had a new spot in the dining room and had to be the first one to go in and the last one to leave. RN-C stated they were completing hourly checks on R1 had and to keep him in sight at all times. RN-C stated she had received the updates on a form for staff to read and sign during report.

During an interview with the Corporate Nurse Consultant for the facility on 4/18/24 at 10:35 a.m., it was indicated that the intention of the intervention for R1 to be the first and last resident in and out of the dining room was to provide supervision by staff.

During interview on 4/18/24 at approximately 10:40 a.m., The ADON stated since the incident occurred on 4/13/24, R1 was now seated at a table in the dining room with a male resident and his back to the rest of the residents. The administrator stated they had consulted with the psychiatrist and discussed and received consent for the addition of an anti-psychotic medication. Regarding supervision during non dining hours, the ADON stated when R1 was in common areas, staff had to keep eyes on him.

During interview on 4/19/24 at 10:43 a.m., the DON stated the facility had not implemented a plan for 24-hour supervision of R1 because they did not think R1 would display inappropriate touching of female residents in the public areas of the facility. She further indicated that the intention of the intervention to have R1 to be the first and last resident in and out of the dining room was to ensure supervision while in dining room, which was not effective in preventing abuse on 4/13/24

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F 600 — Continued From page 9 — F 600

because staff left him unsupervised. DON stated new intervention were introduced and staff had been immediately trained.

Facility abuse prevention policy was requested but not received.

The past noncompliance immediate jeopardy began on 4/13/23. The immediate jeopardy was removed, and the deficient practice corrected by 4/15/23, after the facility implemented a systemic plan that included the following actions:
- The facility implemented a plan to ensure R1 was supervised while in common areas of the facility and without access to vulnerable residents.
- Audits have been initiated to ensure R1 was not left unsupervised in dining room.
- Facility updated R1's care sheet and care plan and provided education to staff on changes and updates.

F 609 SS=D — F 609 — 5/17/24

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 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

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F 609	Continued From page 10 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 ensure resident to resident abuse was reported to law enforcement for 2 of 2 residents (R1, R2) reviewed for sexual assault. Findings include: R1's Resident Face Sheet identified diagnosis that included Alzheimer's, dementia, anxiety and depression. R1's quarterly Minimum Data Set (MDS) identified severe cognitive impairment and indicated he required assistance with transfer and self-propelled in his wheelchair. R1's Service Plan Modification Report identified inappropriate actions and touching female residents. R1's Progress Note dated 4/13/24, indicated nursing assistant (NA) reported to staff that R1 was rubbing the genital area of a female resident (R2). NA stated R1 had his left hand on R2's upper thigh and his right hand was rubbing back and forth on her genitalia. No nursing staff were in the dining room at the time of the incident.	F 609	In response to reporting of alleged violations the facility must have evidence that any suspicion of a crime are reported to law enforcement. Two different reports of sexual assaults were not reported to law enforcement at the time of the VA or during the investigation. Pennington County Law Enforcement was notified of the incident from 4/13/24. The city police office took the information of the allegation and investigation along with names of the residents involved and staff witnesses. The officer information was entered into TRCC's incident report. The officer informed the DON that no report or investigation would take place due to age and diagnoses of both residents. Policies were reviewed and no additional updated were needed at this time All resident have a right to report a suspected crime and have law enforcement notified. DON or designee	

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F 609	Continued From page 11 R2's Resident Face Sheet identified diagnosis that included Hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), schizoaffective disorder, depression, anxiety and aphasia (disorder that results from damage to portions of the brain that are responsible for language). R2's annual MDS indicated severe cognitive impairment and indicated she did not display behaviors. R2's Service Plan Modification Report indicated she preferred a stop sign to keep wanderers out of her room, added 4/4/24. R2's Resident Progress Note dated 4/15/24, indicated R2 was asked about the events on 4/13/24, and stated "I was scared but I don't let him bother me. I'll yell again." During observation and interview on 4/17/24 at 7:27 p.m. R2 was in her wheelchair in her room watching television. R2 stated she remembered the incident from 4/13/24. When asked if she was afraid, R2 said "well, not afraid, I was trying to get away." R2 further stated it had made her uncomfortable. During interview on 4/19/24 at 11:40 a.m. the director of nursing stated the incident had not been reported to law enforcement and said she was not aware of the requirement to report. Facility policy Reporting Reasonable Suspicion of a Crime dated 10/3/16, indicated the facility must report a "reasonable suspicion of a crime" against a vulnerable adult to the Minnesota Adult Abuse Reporting Center (law enforcement) and the state agency.	F 609	will look through incidents and VAs to determine reasonable suspicion of a crime occurred and needs to be completed. Staff will be trained on reporting reasonable suspicion of a crime, and updated Notice fo reporting will be posted throughout the facility. Staff will also be trained to document law enforcement notification on any incidents and potential VAs were a reasonable suspicion of a crime occurred . DON or designee will do daily review of incident reports for potential crimes and VAs. 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.	

Minnesota Department of Health

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2 000	Initial Comments	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 4/17/24 through 4/19/24 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

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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed. H52523244C (MN102496) with no licensing orders issued. As a result of the investigation, licensng orders were 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		

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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		5/17/24

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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 ensure resident to resident abuse was reported to law enforcement for 2 of 2 residents (R1, R2) reviewed for sexual assault.

Provider's Plan of Correction: Corrected

Findings include:

R1's Resident Face Sheet identified diagnosis that included Alzheimer's, dementia, anxiety and depression. R1's quarterly Minimum Data Set (MDS) identified severe cognitive impairment and indicated he required assistance with transfer and self-propelled in his wheelchair. R1's Service Plan Modification Report identified inappropriate actions and touching female residents.

R1's Progress Note dated 4/13/24, indicated

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21980	Continued From page 4	21980		

nursing assistant (NA) reported to staff that R1 was rubbing the genital area of a female resident (R2). NA stated R1 had his left hand on R2's upper thigh and his right hand was rubbing back and forth on her genitalia. No nursing staff were in the dining room at the time of the incident.

R2's Resident Face Sheet identified diagnosis that included Hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), schizoaffective disorder, depression, anxiety and aphasia (disorder that results from damage to portions of the brain that are responsible for language). R2's annual MDS indicated severe cognitive impairment and indicated she did not display behaviors. R2's Service Plan Modification Report indicated she preferred a stop sign to keep wanderers out of her room, added 4/4/24.

R2's Resident Progress Note dated 4/15/24, indicated R2 was asked about the events on 4/13/24, and stated "I was scared but I don't let him bother me. I'll yell again."

During observation and interview on 4/17/24 at 7:27 p.m. R2 was in her wheelchair in her room watching television. R2 stated she remembered the incident from 4/13/24. When asked if she was afraid, R2 said "well, not afraid, I was trying to get away." R2 further stated it had made her uncomfortable.

During interview on 4/19/24 at 11:40 a.m. the director of nursing stated the incident had not been reported to law enforcement and said she was not aware of the requirement to report.

Facility policy Reporting Reasonable Suspicion of a Crime dated 10/3/16, indicated the facility must

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21980	Continued From page 5 report a "reasonable suspicion of a crime" against a vulnerable adult to the Minnesota Adult Abuse Reporting Center (law enforcement) and the state agency. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all suspicions of a crime within appropriate timeframes for reporting. The facility could re-educate staff to policies and procedures, and audit all suspicions of a crime 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. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		