Electronically Submitted
May 16, 2022

Administrator
Paynesville Health Care Center
200 First Street West
Paynesville, MN 56362

RE: CCN: 245253
Cycle Start Date: May 2, 2022

Dear Administrator:

On May 2, 2022, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On April 21, 2022, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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 listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 31, 2022.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 31, 2022, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 31, 2022, (42 CFR 488.417 (b)).

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.

NURSE AIDE TRAINING PROHIBITION

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

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 2, 2022. This prohibition is not subject to appeal. 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.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>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.</u>

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Paynesville Health Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 2, 2022. 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.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Susie Haben, 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 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 November 2, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at 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 DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40,

et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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

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
	245253	A. BUILDING _____ B. WING _____	C 05/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAYNESVILLE HEALTH CARE CENTER	**200 FIRST STREET WEST PAYNESVILLE, MN 56362**

(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 4/28/22 - 5/2/22, 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 complaint was found to be SUBSTANTIATED: H5253038C (MN00082921) with a deficiency cited at F600. The IJ began on 4/21/22, when staff observed R2 lying in R1's bed with her and R1's nightgown was observed to be pulled up to her midsection with her incontinence brief exposed. Although R2 was immediately removed from R1's room, R1 was not assessed for signs of injury/abuse, despite confirming by interview she was touched by R2, and immediate interventions were not put into place for R1 and R2 to prevent future incidences of sexual abuse. The executive administrator (EA) and two corporate nurse consultants (RN-A, RN-B) were notified of the IJ for R1 on 4/28/22, at 8:00 p.m. The IJ was removed on 4/29/22, at 5:00 p.m. when the facility successfully implemented a removal plan. The above findings constituted substandard quality of care, and an extended survey was conducted on 5/2/22. As a result of the extended survey, a deficiency was issued at F841. 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	F 000		

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

Electronically Signed | 05/23/2022

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F 000	Continued From page 1 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=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 protect 1 of 1 residents (R1) from alleged resident to resident sexual abuse when R2, who has a history of wandering into other resident rooms and a history of sexual behavior, entered R1's room unsupervised and was found in bed with her. Further, the facility failed to assess R1 for signs of injury/abuse after the incident and failed to immediately implement safety interventions for either R1 or R2 to help	F 600	Corrective action for the affected resident: R1- R1's care plan was updated on 4/29/22 to indicate that the resident has the potential for trauma related to contact with male peer with interventions to refer to LICSW for counseling if showing signs of trauma and staff to observe for changes in normal routine and content demeanor and update provider and make referrals as needed for	6/10/22

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F 600	Continued From page 2 mitigate the likelihood abuse would occur again. These findings resulted in an immediate jeopardy (IJ) situation for R1 when she was allegedly sexually abused by R2. The IJ began on 4/21/22, when staff observed R2 lying in R1's bed with her and R1's nightgown was observed to be pulled up to her midsection with her incontinence brief exposed. Although R2 was immediately removed from R1's room, R1 was not assessed for signs of injury/abuse, despite confirming by interview she was touched by R2, and immediate interventions were not put into place for R1 and R2 to prevent future incidences of sexual abuse. The executive administrator (EA) and two corporate nurse consultants (RN-A, RN-B) were notified of the IJ for R1 on 4/28/22, at 8:00 p.m. The IJ was removed on 4/29/22, at 5:00 p.m. when the facility successfully implemented a removal plan; however, a non-compliance remained at an isolated scope with no actual harm with potential for more than minimal harm (Level D). Findings Include: A facility submitted SA Incident Report, dated 4/21/22, identified a facility's reported allegation of sexual abuse involved R1 and R2. The report outlined on 4/21/22, at 10:27 p.m. R2 was witnessed "lying" in R2's bed and that R2's nightgown was pulled up with the "bottom half of [R1's] body" exposed. The report identified staff asked R1 if R2 "touched" her and R1 replied in a clear "yes." On 4/28/22, at 10:15 a.m. it was observed R1 and R2 shared adjacent rooms along the West hallway in the facility. Attached to the right side of	F 600	additional support. Social Services will conduct biweekly one to ones to observe for signs of trauma. Resident has baby that she cares for that provides comfort. 3 Stop signs on door while resident is taking afternoon nap and when she goes to bed at night. The facility will take the following measures to ensure that the same practice will not recur: Education was initiated on 4/28/22 for all staff related to areas of concern identified within the IJ: changes to R1 & R2's care plan, Resident event response which included: responding immediately by implementing and documenting interventions to mitigate reoccurrence, need to complete a thorough assessment of the incident including an assessment of the residents, timely completion of notifications and timely care plan updates. Education was completed prior to staffs next scheduled shift. The facility will identify other residents that have the potential to be affected in the same manner by: The Director of Nursing or Designee will complete audits to ensure the direct observation/supervison of R2. Audits will be completed via direct observation to ensure staff is providing 1:1 supervision, 5 audits per week will be completed until reviewed at quarterly Quality Assurance committee. Weekly audits will be completed on daily monitoring sheets to ensure 24 hour supervision until quarterly Quality Assurance committee can review. Facility monitoring of performance to ensure that solutions are maintained: The	

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F 600	Continued From page 3 R1's doorway frame with velcro adhesive were three white cloth mesh pieces of material which hung down alongside the doorframe. A stop sign was present in the middle of each mesh piece. One mesh piece was centered in the door frame with one above and one below by approximately five to seven inches. On 4/28/22, at 10:40 a.m. West hallway video surveillance footage was reviewed and displayed the following: On 4/21/22, at 10:21 p.m. an unidentified staff was seen; however, the footage failed to identify their exact location down the hallway due to the distance from the camera. At that same time, R2 exited his room self propelling his wheelchair. He turned to his right and approached the hospital double doors. At 10:22 p.m. R2 headed back toward his room and entered it at 10:23 p.m. Soon after, he again exited his room, turned to his left, and at 10:24 p.m. entered R2's room which was adjacent to his. At that same time, unidentified staff continued to be seen down the hallway. At 10:27 p.m. staff walked towards R2's room and entered. At 10:28 p.m. another staff entered R1's room. At 10:29 p.m. R2 was brought out of R1's room and escorted to his room. For approximately three minutes, R2 was unsupervised in R1's room. R1's quarterly Minimum Data Set (MDS), dated 4/21/22, identified R1 was severely cognitively impaired with diagnosis of Alzheimer's disease and dementia. She did not speak words; however, was sometimes understood and usually understood others. She required extensive physical assist for cares. R1's progress note (PN), dated 4/21/22, at 10:35 p.m. identified at approximately 10:27 p.m.	F 600	Director of Nursing and/or designee will report the findings of the audits at the quarterly "Quality Assurance" committee and determine if further interventions are warranted as well as to determine the frequency for ongoing audits.	

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F 600	Continued From page 4	F 600		

resident had a situation involving another resident found lying in her bed. Other resident was immediately directed out of the bed and room. Staff provided comfort and when attempting to cover back up with blankets, noted to have night gown pulled up exposing bottom half of body. When asked if R1 was o.k., resident mumbled the word "yes." Asked resident again if o.k. and replied with only mumbling. Asked R1 "did he touch you?" and R1 replied very clear "yes." PN additionally indicated at approximately 10:31 p.m. report was provided for oncoming RN (registered nurse), filing VA (vulnerable adult) report, Approximately 10:33 p.m. updated DON (director of nursing) and Administrator.

An Alleged Abuse incident report, undated, identified R1's 4/21/22, 10:35 p.m. PN information, along with a witness statement which identified a nursing assistant (NA) found R2 "cuddling" with R1, her shirt was up by her stomach, and the NA and the evening RN assisted R2 back to his room. In addition, the report identified the following individuals were notified of the event: 4/22/22, at 9:23 a.m. R2's wife; 4/22/22, at 9:30 a.m. R1's representative (guardian); 4/22/22, at 9:33 a.m. the nurse practitioner (NP). The report lacked documented evidence of any interventions implemented to mitigate the risk of R2 returning to R1's room.

A PN, dated 4/25/22, at 11:38 a.m. identified R1 was observed to have purple bruising to her left upper forearm that measured 5 centimeters (cm) by 3.5 cm and another bruise to the top of her right hand that measured 2 cm by 2 cm. R1 denied anyone had harmed her.

A NP dictated progress note, dated 4/27/22,

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F 600	Continued From page 5	F 600		

indicated R1 was seen and "has been relatively stable." A review of systems was "unobtainable due to the patient's advanced dementia and nonverbal state." Physical exam indicated psychological status as "She does appear to be happy" and there were no changes to her plan of care. The progress note does not reference the 4/21/22 alleged allegation.

R1's medical record was reviewed and lacked documented evidence R1 was assessed for any physical injuries or sign of abuse on 4/21/22, or until her 4/25/22 weekly skin evaluation. In addition, the medical record lacked evidence her mood or psychological status was assessed for any potential adverse impacts related to the alleged allegation.

R1's care plan, dated 4/25/22, identified R1 was considered vulnerable due to compromised medical health as evidenced by her need for nursing home care.

R2's quarterly MDS, dated 4/13/22, identified R2 was moderately cognitively impaired with diagnosis of dementia, Parkinson's disease, and a psychotic disorder with hallucinations. R2 exhibited the following behaviors: physical abuse directed towards others (1 to 3 days), "other" behaviors not directed towards others (1-3 days). The MDS identified R2 was free of wandering behavior; however, he utilized a WanderGuard (device to alert staff of facility exit) daily. R2 was independent with transfers and with walking to and from locations on and off his unit; however, he required limited to extensive physical assist with other activities of daily living (ADLs).

R2's progress note, dated 4/21/22, at 11:04 p.m.

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F 600	Continued From page 6	F 600		

identified the entry: "Resident found lying in another resident's bed. Other resident reported was touched. This resident was easily re-directed out of bed and out of other resident's room. Report filed accordingly."

A progress note, dated 4/24/22, at 4:27 a.m. indicated R2 continued on 15 minute [location] checks. He slept quietly and was free of wandering behavior.

R2's Behavior - Target Symptom Follow Up Question Report, dated 4/1/22 - 4/29/22, identified staff monitored the behaviors of "severe restlessness" and hallucinations. R2's sexually aggressive behaviors and wandering into others rooms was not identified as a target symptom being monitored.

R2's care plan, dated 4/14/22, identified R2 was diagnosed with insomnia (difficulty sleeping), he wandered into others rooms and there was a potential for resident to resident conflict related to his impaired cognition and perception and listed a goal R2 would be free of conflicts with other residents. Interventions directed staff to administer his medications, monitor his behavior(s), remove him and/or other residents from conflict situations, report "assaultive/aggressive" behavior to the nurse, and observe R1 and other residents for signs and symptoms of "agitation/irritation." These were the only interventions listed prior to 4/26/22 to help ensure R1 remained free of abuse. On 4/26/22, R2's resident to resident conflict care plan was updated to include a "long standing history of sexual advances towards others" and his mood and behavior care plan was updated to include "sexually inappropriate towards staff grabbing

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and comments." R2's care plan lacked documented interventions in relation to the incident that occurred on 4/21/22.

R2's medical record was reviewed and lacked evidence R2 was comprehensively assessed by facility staff to help determine contributing factors and subsequent interventions to help reduce and/or eliminate R2's wandering into other residents rooms and sexually aggressive behaviors directed at others.

When interviewed on 4/28/22, at 9:50 a.m. the DON stated during their investigation R1's single mesh stop sign was not engaged across the entire width of her door when R2 entered R1's room. She denied she followed-up with staff or that audits were initiated to ensure the mesh signs were placed as care planned for resident after the incident. She explained R1 was not sent to the emergency room for assessment following the incident as there was lack of suspicion by staff that anything happened that warranted such an examination. "We went by the time on the video. [R2] was in there for only about three minutes before staff entered the room and she had no injuries. [R1] had a body assessment and her nightgown was flipped up but her pad was still up." She indicated she was aware R2 went into other resident rooms, which included R1's room, "That is why the [one] sign was put up in the first place." Further, she indicated, per staff reports, R2 was witnessed to take mesh sign(s) down or "has gone under them" to enter other resident rooms. The DON acknowledged R2 has a history of sexual behaviors, "Just the other day he tried to grab staff;" however, she lacked knowledge if sexual behaviors were directed at other residents. She identified R1's two additional mesh signs

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were added on 4/22/22, along with R2's 15 minute location checks. She denied knowledge of any interventions implemented immediately after the incident on 4/21/22.

During telephone interview on 4/28/22, at 1:48 p.m. R1's guardian stated she was updated on 4/22/22. She indicated she was available by phone 24 hours a day and, "They could have attempted to contact me that night." She acknowledged the alleged allegation was "a pretty serious situation." She explained she "was actually quite shocked that they got a reply from her when they asked her a direct question ...when asked other questions typically she just mumbles."

When interviewed on 4/28/22, at 2:42 p.m. RN-B stated on 4/21/22, around 10:30 p.m. during shift change, she witnessed R2 pushing his wheelchair "wandering" down the hallway and she "had a close eye on him" as she provided the night nurse with report. Shortly after that, she was called into R1's room in which she observed R2 being escorted out of R2's room. RN-B indicated her only questioning to R2 was when she jokingly asked him if he was "getting cuddle time?" She indicated he responded with something that sounded like "ohhhh." When she reentered R1's room, R1's pajamas "were perfectly folded up ...not ruffled or anything ...that did not look right." RN-B pulled down R1's pajamas and covered her back up with the blankets. She explained she questioned R1 if she was okay and R1 "first mumbled a yes." R1 was questioned again if she was okay and R1's response was completely mumbled. She then questioned R1 if R2 touched her and R1 responded "as clear as day yes," which "seemed serious." She denied any

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follow-up questions to R1 and verbalized, "Of course he touched her, he was lying in bed with her. But, that did not mean he did not grab her somewhere." When she was questioned on her incident follow-up, RN-B stated, "Nope, I did not do any. After the fact, I was hoping they would have done something." She confirmed she did not perform a skin check on R1 for potential injury and only visualized R1's exposed stomach area, did not engage with any other residents in the vicinity of R2's room to ensure they were safe, did not set up any interventions to ensure R2 did not reenter R1 or other residents rooms, did not call any resident representative(s) or medical provider(s), and did not call the police. Further, she did not follow-up with staff to investigate the situation further to ensure care plans were followed at the time. She did identify she contacted the DON and administrator and spoke with the night nurse: however, she denies they discussed interventions for either R1 or R2. Once she filled out a written statement for the night nurse to use to fill out the SA report, she ended her shift. "I just assumed they would ensure it would not happen again." She acknowledged the incident was "very serious" and stated, "I should have just did the 15 minute checks." She stated R1 used one stop sign on her door prior to the incident; however, she commented, "We did not always put it up ..." and she was unsure if the stop sign was part of R1's care plan. She explained, " We did not think it was much of a threat for somebody going in her room." She confirmed she had witnessed R2 enter other residents rooms, which included R1's, and commented, "He is everywhere."

During interview on 4/28/22, at 2:11 p.m. licensed practical nurse (LPN-A) stated she did not

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witness the incident between R1 and R2; however, RN-B updated her after. She confirmed she was the only nurse on that night shift. She explained she submitted the SA report after RN-B provided her with the incident information and she spoke to the DON about contacting R1 and R2's representatives that night. She stated the DON instructed her to wait until the morning. LPN-A confirmed she did not perform an overall skin assessment on R1 during her shift, did not contact anyone else, did not engage with other residents in the vicinity of R2's room to ensure they were safe, did not assess R1's mood and/or psychological status during the night, and did not put any interventions into place to protect residents from R2. She identified she and the other night staff only performed prior interventions of checking on both R1 and R2 during routine rounds and if they passed R2's room to make sure he was in there. She stated she had witnessed R2 enter other residents rooms at night prior to this incident and she thought R1's care plan reflected she was to use the mesh stop sign; however, she was not absolutely sure. She confirmed that on 4/25/22, her next scheduled shift, the three mesh slings were in place for R1 and R2 was on routine location checks.

When interviewed on 4/28/22, at 6:00 p.m. RN Nurse Consultant (RN)-A, stated she would expect as part of an abuse allegation investigation the following processes to occur: immediate separation of the individuals involved, observation of the entire situation and gather as much information about the incident as best able, report the incident to the appropriate representatives and medical providers for each resident involved, and file the report with the SA. Further, RN-A indicated she expected staff to

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perform a "basic" skin assessment on the victim to identify any potential concerns that may direct the need for a more comprehensive assessment of injuries, based on the allegation, along with implementing interventions "right away, or at least something in the interim to make sure it does not happen again" until the interdisciplinary team was able to review the incident fully. She provided examples of "someone to keep an eye on him," 15 minute location checks, and one on one supervision if staff availability allowed.

During interview on 4/28/22, at 6:35 p.m. the executive administrator (EA) stated knowledge of the incident. He identified he expected in an alleged abuse situation the victim was to be assessed for any signs of injury and interventions initiated "to make sure the resident does not come back into the room." He explained he would have closed R1's door and kept R2's open for ease of observing R2. He "would expect that the nurses do not leave the area." EA denied knowledge R2 removed or went under the cloth mesh stop signs and explained if this happened staff should implement another stop sign or discuss the possibility of a room change. He denied involvement in conversation(s) related to a room change for R2. He stated he expected the administrator, DON, and social services to investigate abuse allegations thoroughly and follow-up immediately with any concerns identified. Further, he indicated formal staff education related to abuse and the expectation staff follow their abuse policy should have occurred.

When interviewed via telephone on 4/29/22, at 11:16 a.m. NA-A acknowledged she witnessed R2 initially in R2's bed. She explained the evening

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of 4/21/22 she observed R1's call light to be engaged which she thought "was weird ...as she does not use it." She explained she knew R2 was lying down while in R1's bed "as he leaned forward in the bed and then moved his body forward ...he appeared shocked and he had his hand on [R1]'s hip." NA-A provided the following further details: R1 laid slightly on her right side facing the middle of the room and R2 was on his left side and faced her; R2's clothing was on and his genital area was not exposed; R1's sheets were located "down to her knees; " her gown was on and "it was rose up about to her stomach, by her ribs;" her incontinence brief was exposed which was secured and in place; R2's full right hand was directly placed on R1's right hip "below her brief" between her hip and her thigh region and was not actively moving when NA-A observed it on R1's hip. R1 was "wide awake" at the time and when RN-B initially asked R1 questions, "we could not understand what she was saying;" however, when RN-B asked her if R2 had touched her, R1's responded with a "yes" and not her typically mumbled word(s). She indicated she comforted R1 and provided her with her doll after the incident and R1 appeared "the same" as she typically does when they provide cares to her at night. NA-A denied they performed any new interventions that night for either R1 or R2. NA-A stated she has witnessed R2 enter other resident rooms during day and night hours and has witnessed him enter other residents rooms after he removed their mesh sign. He also "can be more touchier sometimes" during cares. She identified interventions utilized for R2 included "closing [resident] doors" and currently "checking on him every 15 to 30 minutes." She explained she did not formally document any location checks for R2 and further explained,

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"Nights is a little hard, especially when me and my co-worker are helping another resident then it is hard to see what R2 is going to do next."

During interview on 4/29/22, at 3:00 p.m. R2's family member (FM)-A stated she is unaware of R2's facility reported history of sexual behaviors: however, she indicated at times "He will tickle one of the nurses on the back of the next ..." She stated R2 had wandered into other resident rooms and she had witnessed him attempting to go underneath the door mesh stop signs to enter another residents room. She explained, due to R2's past profession and history of fixing things, "It [the sign] attracts his attention more than keeping him out. It does slow him down, but I do not think it would stop him."

When interviewed via telephone on 5/2/22, at 12:05 p.m. R1's NP stated she, "was notified the next morning." She verbalized the only interventions discussed for R1 were the stop signs. For R2, they discussed 15 minute checks and inpatient mental health placement; however, "they [staff] did not think it [placement] was needed." She denied conversation occurred related to an sort of assessment of injury for R1. NP explained her expectation for provider notification centered around the "parameters ...based on their procedures." She identified R2 "is going to wander until he cannot" and typically his behaviors were "hit and miss", "waxes and wanes", and were directed more toward staff. She was unsure of his sexual behavior history or his past relationship with his wife.

The immediate jeopardy that began on 4/21/22 was removed on 4/29/22, when the facility assessed R2 and implemented strategies to

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F 600	Continued From page 14 address target behaviors, assessed and implemented strategies to protect R1 from abuse, reviewed and revised incident/abuse policies, retrained staff on new care plan interventions and policies and procedures. A Vulnerable Adult Policy, dated 2/2022, identified residents were to be protected against abuse and did not condone resident abuse by anyone. The policy's abuse definition included sexual abuse. The policy directed staff to complete an internal investigation which included interviews and review of the circumstances and resident records, and victim protection and supportive services as necessary. The policy also directed staff upon identification of suspected abuse, immediate safety was to be provided to the resident with some examples listed as: resident room change; 1:1 monitoring as necessary.	F 600		
F 841 SS=F	Responsibilities of Medical Director CFR(s): 483.70(h)(1)(2) §483.70(h) Medical director. §483.70(h)(1) The facility must designate a physician to serve as medical director. §483.70(h)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a policy and procedure defining the responsibilities of the Medical Director (MD) and ensure the MD assisted in the implementation and guidance of resident care policies, and coordination of resident medical	F 841	Corrective action for the affected resident: A written contract with the Medical Director is in place. The facility developed a policy on the role of the Medical Director in accordance with regulatory requirements. Facility	6/10/22

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F 841	Continued From page 15 care in the facility. This had the potential to impact all 37 residents who resided in the nursing home at the time of the survey. Findings Include: During an extended survey, on 5/2/22, a Medical Director (MD) policy and the MD's job description and/or contract was requested; however, these items were not provided. Due to lack of requested information, the following interviews were conducted: During interview on 5/2/22, at 2:18 p.m. a facility nurse consultant (RN)-C stated the MD was not updated R2 was alleged to have sexually abused R1. Further, RN-C confirmed the MD was not updated on the IJ related to the allegation. She verbalized she did not know why he was not contacted for either concern. When interviewed on 5/2/22, at 2:46 p.m. executive co-owner stated the facility had a contract with the MD for providing services to the facility. He expected the MD to understand the contract and to follow what the contract laid out in terms of what his responsibilities to the facility were. During interview on 5/2/22, at 2:58 p.m. the administrator stated he was not aware if the MD had been updated R2 was alleged to have sexually abused R1 or that the MD was updated on the IJ related to the allegation. The administrator indicated the facility and the MD had a contract for services; however, he lacked knowledge of the contract specifics. He explained the MD participated in their quarterly Quality	F 841	administration is meeting with the Medical Director to review the policy and review the requirements of the role. The facility will take the following measures to ensure that the same practice will not recur: The Medical Director will acknowledge the contract and regulatory requirements of the role. The facility will identify other residents that have the potential to be affected in the same manner by: Random monthly audits will be completed to assure appropriate oversight of required duties of the medical director. Audits will be completed monthly until reviewed at the Quality Assurance committee and with the governing body. Facility monitoring of performance to ensure that solutions are maintained: The Administrator and/or designee will report the findings of the audits at the quarterly "Quality Assurance" committee meeting and with the governing body and determine if further interventions are warranted as well as determine the need/frequency of ongoing audits.	

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Assurance and Performance Improvement (QAPI) program and he has communicated with the MD at times on certain policies; however, overall any facility policies were developed within the "corporation" without MD participation.

When interviewed on 5/2/22, at 3:20 p.m. the MD stated he lacked knowledge R2 was alleged to have sexually abused R1 or that the facility was determined to be in an IJ status related to the allegation. He indicated he expected such allegations and an IJ status were to be reported to him. He explained he started his involvement with the facility, "about May or June of last year," in which he was on medical leave shortly after for approximately six weeks. When he was questioned on the process for medical director coverage when he was unable to fulfill his duties, or who covered for him on his medical leave, he stated, "I do not know to be honest with you....probably one of the partners that rounds there now." He lacked knowledge of a formal process for coverage in his absence. In addition, he stated he did not participate "a lot" in policy development or adjustments as, "Their process for polices is a well-established process...they would know more about nursing home related processes than me." He explained, "They do not tend to contact me; but, there is a quarterly meeting I attend," in which his "role is limited." Further, he identified he reviewed the facility consulting pharmacy reviews; however, has not been required to follow up with any facility practicing providers related to any identified concerns and denied overall communication with these providers since he started his role. The MD stated he lacked knowledge he signed a MD contract with the facility and identified he has "basic knowledge" of his responsibilities as a MD;

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F 841	Continued From page 17 however, "nothing laid out in depth." He stated he has only walked through the facility "once briefly" since he became the MD and explained this was due to COVID-19 regulations. On 5/3/22, at 11:18 a.m. RN-C sent an email to the surveyor which included an attached email sent to the MD on 11/23/21, which identified a written response he would take over as MD after the first of the year. RN-C wrote she heard back from the executive administrator (EA) and they were unable to locate a contract for the MD which pertained to Paynesville Health Care Center.	F 841		

Electronically delivered
May 16, 2022

Administrator
Paynesville Health Care Center
200 First Street West
Paynesville, MN 56362

Re: State Nursing Home Licensing Orders
Event ID: 4YV411

Dear Administrator:

The above facility was surveyed on April 28, 2022 through May 2, 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
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Saint Cloud, Minnesota 56301-4557
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You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00636	A. BUILDING: _____ B. WING _____	05/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAYNESVILLE HEALTH CARE CENTER	200 FIRST STREET WEST PAYNESVILLE, MN 56362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/28/22 - 5/2/22, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5253038C (MN00082921) with no order issued. As a result of the investigation, a licensing order was issued at 1230. 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	2 000		

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2 000	Continued From page 2 not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21230	MN Rule 4658.0700 Subp. 2 B Medical Director; Implement ResCare Policies Subp. 2. Duties. The medical director, in conjunction with the administrator and the director of nursing services, must be responsible for: B. implementation of resident care policies; This MN Requirement is not met as evidenced by: F841 SUGGESTED METHOD OF CORRECTION: The Governing Body or designee could contract with the medical director for facility responsiblities. The Governing Body or desinee could develop policies and procedures on how the medical director could effectively provide required regulated duties to ensure appropriate resident care occured and have a method of monitoring compliance. The Governing Body or designee could develop a system to ensure the medical director provided appropriate oversight and review requried duties. The Governing Body could also develop a monitoring system to ensure residents receive appropriate direction for care and services provided at the facility.	21230	Corrective action for the affected resident: A written contract with the Medical Director is in place. The facility developed a policy on the role of the Medical Director in accordance with regulatory requirements. Facility administration is meeting with the Medical Director to review the policy and review the requirements of the role. The facility will take the following measures to ensure that the same practice will not recur: The Medical Director will acknowledge the contract and regulatory requirements of the role. The facility will identify other residents that have the potential to be affected in the same manner by: Random monthly audits will be completed to assure appropriate oversight of required duties of the medical	6/10/22

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21230	Continued From page 3 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21230	director. Audits will be completed monthly until reviewed at the Quality Assurance committee and with the governing body. Facility monitoring of performance to ensure that solutions are maintained: The Administrator and/or designee will report the findings of the audits at the quarterly "Quality Assurance" committee meeting and with the governing body and determine if further interventions are warranted as well as determine the need/frequency of ongoing audits.	