*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
January 9, 2024

Administrator
Warroad Care Center
1401 Lake Street Northwest
Warroad, MN  56763

RE: CCN: 245329
Cycle Start Date: November 22, 2023

Dear Administrator:

On December 6, 2023, we notified you a remedy was imposed. On January 4, 2024 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 22, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 21, 2023 be discontinued as of December 22, 2023. (42 CFR 488.417 (b))

In our letter of December 6, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 21, 2023. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 245329 | A. BUILDING _____ B. WING _____ | C 12/06/2023 |

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| F 000 | INITIAL COMMENTS<br><br>On 12/4/23 -12/6/23, 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.<br><br>The following complaints were reviewed. H53297538C (MN98898).<br><br>Incidental findings were identified at F609, F610 and F744.<br><br>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.<br><br>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.<br><br>. | F 000 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§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, | F 609 | | 12/22/23 |

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

Electronically Signed | 12/22/2023

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

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| F 609 | Continued From page 1<br>are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to report an injury of unknown origin within 24 hours of it being identified to the State Agency (SA) for 1 of 3 residents (R1) reviewed for potential abuse.<br><br>Findings include:<br><br>R1's significant change Minimum Data Set (MDS) dated 10/10/23, identified R1 had a severe cognitive impairment and a diagnosis of Alzheimer's disease. R1 was dependent on staff for all care areas. R1 exhibited physical and verbal behaviors towards others.<br><br>R1's WSLC Skin Incident Report dated 11/29/30, identified staff reported bruising to R1's | F 609 | There was no way to correct the deficient practice for R1. All residents have the potential to be affected by the deficeint practice. To make sure that the deficeint practice will not reoccur, education on the abuse policy and necessary timliness of VA reporting was reviewed at the CNA meeting on 12-12-23 and at the nurses meeting on 12-14-23. It was also stressed at the meetings the necessity to report all bruises, skin tears, unusual edema etc. to the nurses and the DON if necessary. To monitor that the deficient practice will not reoccur, the DON or designee will audit all VA maltreatment reports for timliness of reporting for six months. All new bruises, skin tears, unusual edema etc will be | |

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| F 609 | Continued From page 2<br>hand/arm/finger. It was reported R1 was combative during cares the evening prior. A bruise to the left wrist measured 8 centimeters (cm) by 26 cm. The top of hand bruise measured 4 cm x 3.4 cm. The right index finger bruise measures 6.2 cm from knuckle. Interventions included a physician order was obtained to get an x-ray, nurse assessment, and taping of the finger if R1 allowed.<br><br>R1's Skin/Wound note dated 11/29/23 at 10:46 a.m., identified R1 had bruising to the left wrist and right hand. Area to left wrist measured 8 x 2.6 cm. The top of the right hand measured 4 x 3.4 cm and her right index finger measured 6.2cm from her knuckle. R1 was noted to have combative behaviors during cares per staff. R1 offered no complaints or signs/symptoms of pain or discomfort. R1 had range of motion within normal limits and utilized hand/finger when eating and holding objects. Orders were obtained to have an x-ray of R1's finger. R1's family was notified. However, the note did not identify when R1's bruising was identified.<br><br>R1's Vulnerable Adult Maltreatment Report dated 12/1/23, identified the facility filed a report to the State Agency on 11/30/23 at 1:40 p.m.<br><br>During an interview on 12/5/23 at 12:09 p.m., nursing assistant (NA)-A stated during morning to evening shift change on 11/28/23, the day shift nurse reported R1's hand was swollen and all red in color.<br><br>During an interview on 12/5/23 at 2:35 p.m., NA-B stated she worked with R1 on 11/28/23. R1's hand was swollen and R1's left arm was bruised, but her right hand was really red, and swollen. | F 609 | reviewed daily in the morning IDT meetings by the DON or designee for six months. Results of the audits will be reported at the monthly QAPI/QA meetings. | |

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| F 609 | Continued From page 3<br><br>During an interview on 12/5/23 at 2:42 p.m., LPN-B stated LPN-B was told about it during report on 11/29/23. Because the injury was reported to LPN-B, she believed everything was done so LPN-B did not report the injury nor document in R1's electronic medical record (EMR). R1 had an x-ray of her finger later that afternoon on 11/29/23, and we were told on 11/30/23, R1 had a small fracture in her finger.<br><br>During an interview on 12/5/23 at 2:52 p.m., RN-B stated during morning to evening report on 11/28/23, LPN-C told RN-B they had to do something with R1's hand. RN-B did not know what LPN-C was referring to, so RN-B went to assess R1 on 11/28/23. RN-B saw R1's hand was very swollen, red and bruised and went to LPN-D to ask what RN-B needed to do. RN-B stated she was instructed by LPN-D to obtain measurements of R1's injury and LPN-D would "take care of it". LPN-D needed to talk to LPN-C to figure out what was going on.<br><br>During an interview on 12/5/23 at 3:38 p.m., LPN-C stated she was unaware of R1's injury until the high risk meeting the morning of 11/29/23, but the injury should have been reported as soon as it was identified.<br><br>During an interview on 12/5/23 at 4:33 p.m., LPN-D stated she recalled someone said something to her in passing on 11/28/23, about R1's bruise. LPN-D could not exactly recall what was said, but gave instruction to measure, document and LPN-D would look at it the next day. "It wasn't told to me in a way that made sense." LPN-D didn't think anything of it because there were two nurses on the floor. LPN-D should | F 609 | | |

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| F 609 | Continued From page 4 | F 609 | | |

have reported R1's injury to the State Agency (SA) on 11/28/23, and documented in R1's electronic medical record (EMR) when she was notified on 11/28/23.

During an interview on 12/6/23 at 6:20 a.m., RN-C stated she was informed of R1's injury on 11/28/23, during shift change. RN-C worked with R1 on 11/27/23, but R1 was wearing long sleeves. R1 did not do anything new. R1 always cried out or was combative, so RN-C stated she didn't think anything of it. When RN-C arrived at the facility on 11/28/23, RN-B stated "did you see all those bruises on" R1. RN-C assessed R1 and observed a large bruise to R1's left arm and R1's right hand was swollen and red. When RN-C touched R1's arm it was "evident" R1 was having discomfort. That morning, RN-C had another registered nurse look at it. However, RN-C did not file a report to the SA nor documented the injury in R1's EMR.

During an interview on 12/6/23 at 8:47 a.m., NA-E stated R1's right hand was swollen, red and bruised the morning of 11/28/23. NA-E immediately notified RN-B. On 11/28/23, at approximately 11:30 a.m., NA-E observed RN-B measure R1's bruises with a tape measure. When RN-B pulled up R1's left sleeve there was a large purple bruise to R1's left forearm. R1's arm looked horrible and R1's right index finger was puffy, and it couldn't be missed.

During an interview on 12/6/23 at 9:55 a.m., LSW stated she was informed of R1's injury on 11/28/23, and it should have been reported to the SA when discovered.

During an interview on 12/6/23 at 12:45 p.m., the

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| F 609 | Continued From page 5<br>DON stated she assessed R1's injuries as soon as she was notified and insisted an x-ray be obtained. The DON was unaware staff identified R1's injury on 11/28/23. Staff were expected to assess, document and report according to facility policy.<br><br>The facility policy Resident Abuse Prohibition Policy revised 6/7/23, defined injuries Of Unknown Source as follow:<br>a. The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and,<br>b. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.<br>The policy identified clinical indicators of physical abuse included fractures, especially on non-ambulatory adults.<br>The policy directed an owner, licensee, administrator, licensed nurse, employee, contracted provider, or volunteer of a nursing home shall not physically, mentally, or emotionally abuse, mistreat, or harmfully neglect a resident. Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, or misappropriation shall immediately but no later than two hours, report concern to either a care coordinator, DON, or LSW. The administrator will then be immediately notified of allegation and a report made to the state agency by the person who received report. The Nursing Home Administrator or designee will report abuse/allegations of mistreatment or suspected abuse immediately to the SA per State and | F 609 | | |

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| F 609 | Continued From page 6<br>Federal requirements. | F 609 | | |
| F 610 SS=D | Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to thoroughly investigate an injury of unknown source to ensure resident safety and appropriate interventions were implemented for 1 of 3 residents (R1) reviewed for potential abuse.<br><br>Findings include:<br><br>R1's significant change Minimum Data Set (MDS) dated 10/10/23, identified R1 had a severe cognitive impairment and a diagnosis of Alzheimer's disease. R1 was dependent on staff for all care areas. R1 exhibited physical and verbal behaviors towards others. | F 610 | There was no way to correct the deficient practice for resident R1. A final investigative report was sent to MDH and resident R1's care plan was reviewed and updated for behaviors with appropriate interventions. All residents have the potential to be affected by the deficeint practice. Systemic changes to be put into place will be a collaborative approach to investigations of potentail abuse by the LSW and DON. All nursing staff were educated about the necessity of reporting and documenting all resident injuries at a CNA meeting on 12-12-23 and at a | 12/22/23 |

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| F 610 | Continued From page 7<br><br>R1's WSLC Skin Incident Report dated 11/29/30, identified staff reported bruising to R1's hand/arm/finger. It was reported R1 was combative during cares the evening prior. A bruise to the left wrist measured 8 centimeters (cm) x 26 cm. The top of hand bruise measured 4 cm x 3.4 cm. The right index finger bruise measures 6.2 cm from knuckle. Interventions included a physician order was obtained to get an x-ray, nurse assessment, and taping of the finger if R1 allowed.<br><br>R1's Skin/Wound note dated 11/29/23 at 10:46 a.m., identified R1 was noted to have bruising to left wrist and right hand. Area to left wrist measured 8 x 2.6 cm. The top of the right hand measured 4 x 3.4 cm and her right index finger measured 6.2 cm from her knuckle. R1 was noted to have combative behaviors during cares per staff. R1 offered no complaints or signs/symptoms of pain or discomfort. R1 had range of motion within normal limits and utilized hand/finger when eating and holding objects. Orders were obtained to have an x-ray of R1's finger. R1's family was notified. However, the note did not identify when R1's bruising was identified.<br><br>R1's Vulnerable Adult Maltreatment Report dated 12/1/23, identified the facility filed a report to the State Agency on 11/30/23 at 1:40 p.m.<br><br>The Warroad Senior Living Center Staffing Hours form dated 11/26/23 through 11/28/23, identified the following staff members were working and had opportunity to have contact with R1: RN-C, RN-D, RN-E, LPN-A, LPN-B, NA-A, NA-D, NA-E, NA-G, NA-H, and NA-J. | F 610 | nursing meeting on 12-14-23. The DON or designee will monitor the corrective actions by auditing nursing documentation daily at morning IDT meeting for three months. The DON or designee will report audit results to the QAPI/QA meetings on a monthly basis. | |

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| F 610 | Continued From page 8<br><br>The facility investigation was requested and identified the following: R1's Vulnerable Adult Internal Investigation Form updated 6/9/23, identified on 11/30/23 at 1:32 p.m., R1 was noted to have a bruise to her left wrist/forearm and the top of her right hand. She was also suspected to have a fractured finger. R1 was noted to be combative during standing lift transfers prior. The form identified the care plan was followed. A ceiling lift was assessed for R1 by a licensed practical nurse, registered nurse, and restorative therapist. R1 was comfortable and safe, no hollering or lashing out. R1's family agreed to switch to ceiling lift transfers. Other case notes: Nursing Assistant (NA)-D was terminated on Tuesday, 11/28/23. NA-D worked with R1 in the days prior to her termination and NA-D was observed to transfer R1 without following the care plan appropriately. The following staff interviews were included: licensed practical nurse (LPN)-B, LPN-A, NA-E, NA-F, and registered nurse (RN)-B. The form failed to identify all staff, with possible interaction with R1 nor other residents with contact with NA-D, were interviewed to determine if an injury occurred during a transfer when the care planned was not followed. Nor did the investigation identify any observation of care provided.<br><br>During an interview on 12/5/23 at 12:09 p.m., NA-A stated during morning to evening shift change on 11/28/23, the day shift nurse reported R1's hand was swollen and all red in color. NA-A stated she was not interviewed regarding R1's bruising.<br><br>During an interview on 12/5/23 at 2:35 p.m., NA-B stated she worked with R1 and R1's hand was | F 610 | | |

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| F 610 | Continued From page 9<br>swollen. R1's left arm was bruised, but her right hand was really red and swollen. NA-B stated she was not interviewed regarding R1's bruising and was not aware of what happened.<br><br>During an interview on 12/5/23 at 2:42 p.m., LPN-B assumed R1 hit her hand on the standing lift during a transfer. "Where else would it come from?"<br><br>During an interview on 12/5/23 at 3:49 p.m., NA-C stated she worked with R1 on 11/28/23. R1 was behavioral and NA-C could not calm her down. NA-C stated R1 hit, punched, kicked, and NA-C had to ask LPN-D for assistance. NA-C did not believe R1 injured herself, but LPN-D sat with her. If a resident did hurt themselves, NA-C would ask for the nurse immediately. NA-C stated she not was interviewed regarding R1's bruising.<br><br>During an interview on 12/5/23 at 4:33 p.m., LPN-D stated she recalled someone said something to her in passing on 11/28/23, about R1's bruise. LPN-D could not exactly recall what was said, but gave instruction to measure, document and LPN-D would look at it the next day. LPN-D didn't think anything of it because there were two nurses on the floor. Staff were busy, but it was passed on in the morning during report. On 11/29/23, LPN-D brought her concerns to the director of nursing (DON) and the social worker (SW)-A. LPN-D then stated she as aware of R1's injury on 11/28/23, and also a nursing assistant had been let go that day due to unsafe practices. Staff reported the nursing assistant had not wanted to listen to direction and LPN-D witnessed an unsafe resident transfer; however, there was no evidence to identify any injury occurred during the transfer | F 610 | | |

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| F 610 | Continued From page 10<br><br>During an interview on 12/6/23 at 6:20 a.m., RN-C stated she was informed of R1's injury on 11/28/23, during shift change. RN-C worked with R1 on 11/27/23, but R1 had been wearing long sleeves. R1 did not do anything new. R1 always cried out or was combative, so RN-C stated she didn't think anything of it. When she arrived at the facility on 11/28/23, RN-B stated "did you see all those bruises on" R1. RN-C assessed R1 and observed a large bruise to R1's left arm and R1's right hand was swollen and red. When RN-C touched R1's arm it was "evident" R1 was having discomfort. That morning, RN-C had another registered nurse look at it.. RN-C stated R1 hit out during cares and R1 would try to hit you just by talking to R1. RN-C stated she was told NA-D transferred R1 without using a lift and NA-D was terminated on 11/28/23. RN-C stated she was not interviewed by leadership regarding R1's bruising.<br><br>During an interview on 12/6/23 at 8:47 a.m., NA-E stated R1's right hand was swollen, red and bruised the morning of 11/28/23. NA-E observed a large purple bruise to R1's left forearm. R1's arm looked horrible. R1's right index finger was puffy. NA-E stated NA-D performed R1's cares that morning. NA-E told LPN-D of NA-D transferring R1 without using a lift and NA-E was terminated later that day at the end of her shift; however, there was no evidence to identify any injury occurred during the transfer.<br><br>During an interview on 12/6/23 at 9:55 a.m., SW-A stated she was informed of R1's injury on 11/28/23. Staff found out that R1 was transferred without the care planned interventions by NA-D on 11/28/23 and NA-D was terminated later that day, although there was no evidence and injury | F 610 | | |

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| F 610 | Continued From page 11<br>occured during the transfer. SW-A stated she did not interview all staff who had potential contact with R1 nor spoke with NA-D.<br><br>During an interview on 12/6/23 at 12:45 p.m., the director of nursing (DON) stated she assessed R1's injuries as soon as she was notified and insisted an x-ray be obtained. The DON was unaware staff had identified R1's injury on 11/28/23. The investigation should include who, what, when and where to determine the resident and the other residents were safe. The follow up investigation had been completed and submitted to the SA. Staff were expected to investigate according to facility policy.<br><br>The facility policy Resident Abuse Prohibition Policy revised 6/7/23, defined injuries Of Unknown Source as follow:<br>a. The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and,<br>b. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.<br>The policy identified clinical indicators of physical abuse included fractures, especially on non-ambulatory adults. The policy directed the investigation would consist of at least the following:<br>a. A review of the completed complaint report<br>b. An interview with the person or persons reporting the incident.<br>c. Interviews with any witnesses to the incident<br>d. A review of the resident medical record if indicated. | F 610 | | |

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| F 610 | Continued From page 12<br>e. An interview with staff members having contact with the resident during the relevant periods or shifts of the alleged incident.<br>f. Interviews with the resident's family members, and visitors (if applicable)<br>g. other residents in the staff's care.<br>h. A root cause analysis of all circumstances surrounding the incident.<br>i. Investigation of involuntary seclusion should include:<br>- Symptoms that led to the consideration of the separation<br>- Investigation into whether the symptoms were caused by failure to meet resident needs, provide meaningful activities or manipulation of the resident environment<br>- Was the cause of the symptom removed?<br>- Were alternatives attempted prior to separation?<br>- Was the separation for the least amount of time necessary?<br>- Was the family/legal representative involved in the care planning and informed choice regarding the separation?<br>- Is there evidence of monitoring and adjustments in care to reduce negative outcomes and attempt to determine less restrictive alternatives?<br>j. While the investigation is being conducted, accused individuals not employed by the facility will be denied unsupervised access to the resident. Visits may only be made in designated areas, supervised by staff after approval by the Administrator.<br>k. The Administrator will keep the resident or his/her representative informed of the progress of the investigation.<br>l. The results of the investigation will be recorded and attached to the report.<br>m. The Administrator or designee will complete a copy of the investigation materials. | F 610 | | |

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| F 610 | Continued From page 13<br>n. The Administrator or designee will inform the resident and/or his/her representative of the results of the investigation and corrective action taken.<br>m. Inquiries made concerning abuse reporting and investigation must be referred to the Administrator or to the Director of Nursing. | F 610 | | |
| F 744 SS=D | Treatment/Service for Dementia<br>CFR(s): 483.40(b)(3)<br><br>§483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to assess for dementia related behaviors and implement individualized resident centered interventions to managed the dementia symptoms for for 2 of 3 residents (R3, R1) reviewed for potential abuse.<br><br>Findings include:<br><br>R3<br><br>R3's annual Minimum Data Set (MDS) dated 9/22/23, identified R3 had severe cognitive impairment and a diagnosis of dementia. R3 exhibited physical and verbal behaviors toward others.<br><br>R3's cognitive Loss/Dementia CAA dated 9/22/23, identified R3 demonstrated behavioral symptoms during the review period, including physical and verbal. R3 had a diagnosis of dementia which | F 744 | To correct the deficient practice, a behavior assessment [MDS Section E] was completed and the care plan for resident R1 was reviewed and updated to contain individualized resident specific intervention for her behaviors related to her dementia. A social service assessment was done on resident R4 and an individualized dementia care plan was developed and implemented. A behavior assessment [MDS Section E] was also done on resident R4 and behavioral care plan was updated. Resient R1 had been progressively declining and expired on 12-12-23. All residents were identified to have the potential to be affected by the deficient practice. All of the residents had a behavioral assessment [MDS Section E] done and care plans were reviewed and updated as necessary for residnt centered interventions for specific behaviors. To | 12/22/23 |

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| F 744 | Continued From page 14<br>was the primary contributing factor to her cognitive function decline and behavioral symptoms. R3 also had a diagnosis of major depressive disorder that may contribute to her symptoms. R3 had a WanderGuard in place to reduce risk for elopement. Staff would continue with current interventions related to cognitive impairment and proceed to care plan.<br><br>R3's care plan revised 11/27/23, identified R3 exhibited delusions, accusations, statements of depression and confusion. Interventions included dementia approach, redirection, 1:1 with staff, family support and reassurance. R3 had a history of bearing down when getting on/off toilet and voiding having a bowel movement on staff. The care plan failed to identified the resident centered intervention for specific behaviors.<br><br>During an observation on 12/5/23 at 10:50 a.m., licensed practical nurse (LPN)-A attempted to assist R3 with her morning cares and the room was quiet. R3 was lying in bed on her back with a t-shirt on without pants. A throw blanket was covering R3 from the waist down. LPN-A approached R3 holding a lift sling, bent over R3, approximately 6 inches from R3's face, and stated loudly to R3 "let's get you up for the day." R3 became angry and stated "quit spitting in my face!" LPN-A laughed and stated she wasn't spitting, she was talking to R3. R3 attempted to punch LPN-A, but LPN-A stepped out of the way. R3 stated to LPN-A "leave me alone!" LPN-A tossed the lift sling into R3's wheelchair and laughingly stated "I guess we will try again later." LPN-A shrugged her shoulders and stated R3 was dry and she just didn't know what to do with R3. | F 744 | ensure that the deficeint practices will not reoccur, LPN A was counseled by hte DON about her approach and demeanor when working with residents with dementia. The LSW will do a social services assessment on all new admissions and quarterly thereafter. At the monthly CNA meeting on 12-12-23 education was provided regarding documentation on behaviors and care of the residents. At the monthly nurses meeting on 12-14-23 education about the necessity of accurate and complete documentation was done. All nurses received a copy of the book "Straight to the Point Documentation Guide for LTC/SNF Nurses by KLK Strategies. To monitor the corrective action to ensure that the deficent practice will not reoccur, the DON or designee will audit the progress notes for accurate and complete nursing docuemntation at the morning IDT meeting 5 times per week for 3 months. Results of the audits will be reported to the monthly QAPI/QA meetings. | |

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| F 744 | Continued From page 15<br>During an interview on 12/5/23 at 10:58 a.m., R3 stated "I just hate it here. I ask them to leave and they don't they just keep on. I'm all locked up." R3 pointed to her lower abdomen and shrugged. "They think it's funny. I hate them. I just want to be left alone."<br><br>During an interview on 12/5/23 at 2:32 p.m., nursing assistant (NA)-B stated R3 was always good with her because R3 liked "Elvis" and NA-B sang with R3. NA-B stated other staff told her R3 refused cares, but R3 had never done that with NA-B. R3 had to have an incentive,and make it worth her while to do something. R3 loved music so NA-B always turned on the music before starting cares and R3 would cheer up.<br><br>During an interview on 12/6/23 at 11:12 a.m., NA-E stated R3 was combative with NA-E once, but NA-E was told it happened a lot. R3 seemed to be "crankier" lately as well. R3 didn't like to be cold or get out of bed. It had to be her idea to. You had to ask and if R3 said no, you go back in 15 minutes and try again. Staff needed to turn on R3's music before you left the room too. R3 liked Elvis or 50-60's music. It just improved R3's mood.<br><br>During an interview on 12/5/23 at 4:27 p.m., LPN-D stated R3's care plan did not identify specific behavior triggers nor resident centered interventions for the behavioral triggers.<br><br>R1<br><br>R1's significant change MDS dated 10/10/23, identified R1 had a severe cognitive impairment and a diagnosis of Alzheimer's disease. R1 was dependent on staff for all care areas. R1 | F 744 | | |

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| F 744 | Continued From page 16<br>exhibited physical and verbal behaviors towards others.<br><br>R1's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 10/10/23, identified R1 had severe cognitive impairment. R1 would sometimes respond to the interview questions but responses were nonsensical. R1 demonstrated inattention, disorganized thinking; and behavioral symptoms including physical and verbal symptoms towards others. Primary factor related was her diagnosis of Alzheimer's type dementia. R1 also had a diagnosis of unspecified mood (affective) disorder and adjustment disorder with mixed anxiety and depressed mood. Non-pharmacological interventions are also included in her care plan to help prevent and manage her symptoms. R1's cognitive impairment did affect her ability to participate in ADL's, activities, and daily decision making. R1 had more difficulty with communicating and comprehending than she had in the past related to disease progression, as well as decline in physical abilities. R1's care plan would continue to include interventions to promote as much participation as possible with the above with support and assistance as necessary.<br><br>R1's care plan revised 10/13/23, identified R1 displayed the following target behavioral symptoms: irritability, agitation, teary eyed, crying, lashing out at staff verbally and physically, refusal of cares, loss of interests. Interventions included non-pharmacological interventions of: one to one staff, family support, interaction with husband, activities of choice, distraction, reassurance, use dementia approach: facial expressions that sparkle, get below eye level, introduce yourself,offer handshake, offer endorphin | F 744 | | |

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| F 744 | Continued From page 17<br>booster, explain what is going to happen next. Use seven words or less in a sentence, speak low and slow, no questions, no up talking. Avoid saying no to the resident and offer snack. When resident was overstimulated and agitated, place resident out of arms distance from other residents. The care plan failed to identified the resident centered intervention for specific behaviors and how to approach the resident with her cares.<br><br>R1's Kardex dated 12/5/23, identified R1 exhibited behaviors. The Kardex directed staff to:<br>- Monitor behavior episodes and attempt to determine underlying cause.<br>- Consider location, time of day, persons involved, and situations.<br>- Document behavior and potential causes.<br>The Kardex failed to identify R1's behavior triggers nor provided resident centered interventions.<br><br>R1's Behavior Symptoms AR dated 11/6/23 through 12/6/23, identified R1 exhibited frequent crying, repetitive movements, yelling/screaming, kicking/hitting, pushing, grabbing, pinching/scratching, spitting, biting and rejection of care 22 out of 30 days. The non-pharmacological interventions used were other individualized approach per resident care plan/Kardex, dementia approach, ensure safety, redirection, and reassurance. The documentation did not provide a description of the incidents nor if the non-pharmacological interventions were effective.<br><br>During a telephone interview on 12/5/23 at 8:51 a.m., family member (FM)-A stated R1 was unable to express herself due to the progression | F 744 | | |

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| F 744 | Continued From page 18<br>of her dementia which was worsening over the past year. Staff reported to FM-A, R1 frequently lashed out at staff, especially during cares and FM-A observed R1 to lash out at staff as well. FM-A was usually not at the facility when R1 was assisted to bed, but FM-A could see how R1's cognition worsened as the day went on, so behaviors would too.<br><br>During an observation on 12/5/23 at 10:24 a.m., LPN-A and LPN-B provided cares to R1. R1 was in bed, lying on her left side with her eyes closed. LPN-A pulled back R1's blankets and stated, "hey dolly." R1 did not respond. LPN-A stated R1's incontinent product was soaked through and soiled the reusable incontinent pad under R1. LPN-B attempted to wake R1, but R1 made no response. LPN-A rolled R1 to the left and R1 suddenly opened her eyes and yelled out "Hey!" and began to reach out to LPN-A. LPN-A stepped back and stated "hey, don't pinch." then stated, "it's not bad unless she gets the fat of your arm." R1 began to weep and LPN-B stroked R1's shoulder and whispered, "don't cry." R1 continued to have facial grimacing and wept. LPN-A began cleaning feces from R1's side and removed R1's soiled incontinent product. LPN-A stated "oh, we have a mess today. I guess that's better than not working." LPN-A then told LPN-B "just watch her hands so she doesn't get me." LPN-B continued to hold R1's hands while R1 crossed her arms over her chest.<br>- LPN-A rolled R1 to the right. LPN-A took a disposable wipe and wiped feces from R1's bottom. LPN-A then said to R1 "I'm going to wipe you, dolly." R1 attempted to kick LPN-A with her left leg but LPN-A stepped out of the way. LPN-A stated R1 was just not happy, and LPN-A did not know how to fix her anymore. LPN-A rolled R1 to | F 744 | | |

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| F 744 | Continued From page 19<br>the left, then stated "I'm going to turn you now". R1 yelled out "oh no!" LPN-A continued to roll R1 who yelled "Cut it out!" R1 attempted to hit LPN-A, but LPN-B held her hands. LPN-B stated to R1 "let's make it all better." LPN-A cleaned between R1's thighs without saying anything to R1. R1 yelled "No!" LPN-B whispered to R1 that it was ok, they just needed to get R1 clean down there. LPN-A and LPN-B repositioned R1 in her bed by lifting R1 by the reusable incontinent pad without saying anything to R1. R1 yelled "Oh!" and pinched LPN-B. LPN-B stated to R1 "you got the love roll there" after stepping out of R1's reach. R1's yelled out "daddy, help me!" LPN-A rolled to R1 to the right while LPN-B tucked a pillow behind R1's back for comfort. LPN-B stated to R1 "you're ok. We're done traumatizing you for a little bit here. LPN-A and LPN-B exited R1's room. LPN-B stated that it just breaks your heart.<br><br>During an observation on 12/05/23 at 3:36 p.m., R1 was lying in bed and RN-A repositioned R1 for comfort. RN-A repeatedly explained each step in a calm, low volume to R1 before beginning the step. R1 remained calm. R1 was wearing long sleeves and RN-A assessed R1's right hand and right index finger bruising. RN-A stated R1's right index finger was slightly swollen, bruising, dark purple to the second knuckle, all the way around the finger. R1 did not withdraw from RN-A touch.<br><br>During an interview 12/5/23 at 12:09 p.m., (NA)-A stated R1 was aggressive. R1 didn't understand what was going on so her first reaction was to attack someone. The biggest thing was one person held R1's hands because she hit and pinched. The other person undressed her "and stuff". If R1 said no, staff usually took a small break. If R1 started to cry staff stopped, NA-A still | F 744 | | |

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| F 744 | Continued From page 20 | F 744 | | |

held her hand and let R1 see NA-A. NA-A talked until R1 calmed down. Most likely R1 hit out. The nursing assistants were supposed to tell the nurse when R1 was combative during cares.

During an interview on 12/5/23 at 1:42 p.m., LPN-B stated R1 was so fast. R1 went from zero to sixty in a flash. Once, LPN-B was assisting R1 to eat ice cream and R1 said no, but was still eating the ice cream. LPN-B kept giving her spoonfuls and, suddenly, R1 stated "I said no!" and LPN-B had "supplement all over me." You just don't see it coming. LPN-B stated she used to think it was pain, but wasn't sure anymore. R1's medications really didn't seem to make a difference and LPN-B stated she didn't know how to help R1. It was one thing when R1 was combative. Combative meant get out. The nursing assistants should always report that to the nurse and it should be documented.

During an interview on 12/5/23 at 2:35 p.m., NA-B stated R1 usually wasn't combative with her. You have to go really slow and repeatedly tell R1 what your' e doing.

During an interview on 12/5/23 at 2:45 p.m., RN-A stated R1 could become combative, refuse medications, grab and pull away. If R1 refused cares, RN-A would do as much as she could without escalating the situation. You do what you can and call it a day. Refusal of care or combative behaviors should be documented.

During an interview on 12/5/23 at 2:52 p.m., RN-B stated R1 can be combative: hit, punch, kick, spit and/or bite. Loud noises would set R1 off. R1 didn't like to be surrounded by large groups. Combative behaviors should be

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 744 | Continued From page 21<br>assessed and documented.<br><br>During an interview on 12/5/23 at 3:49 p.m., NA-C stated R1 would hit and kick. R1 could potentially hurt herself or you. NA-C would try to talk to R1 to calm her down or let the nurse know.<br><br>During an interview on 12/5/23 at 4:27 p.m., LPN-D stated R1 exhibited behaviors: hitting out, combativeness, hollered out, and more so whenever staff tried to do stuff with R1. Loud noises sometimes would bother R1, sometimes not. Sometimes R1 would be out at the table and did well and other times she struggled more. Staff usually assisted R1 to eat in quiet places. Bed time and sleeping were the worst times. R1 liked hymns and quieter music. LPN-D stated R1's care plan did not identify R1's possible behavior triggers nor directed staff how to prevent the behaviors.<br><br>During an interview on 12/6/23 at 6:20 a.m., RN-C stated R1 lashed out during cares, but it didn't have to be cares. R1 would try to punch someone just for talking to her. R1's dementia was severe and R1 could not remember what was happening. Staff needed to continually cue R1.<br><br>During an interview on 12/6/23 at 8:47 a.m., NA-E stated she had to go painfully slow with R1. The nurses would get mad with NA-A because it took too long. NA-E continually told R1 what was happening. If you didn't, R1 would get startled, doesn't understand and lashed out. NA-E stated she had never been hit by R1 but had been told by many that R1 was combative. Staff just pulled back the blankets and start. I wouldn't want that, would you? | F 744 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245329 | A. BUILDING _____ B. WING _____ | C 12/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 744 | Continued From page 22<br><br>During an interview on 12/6/23 at 12:37 p.m., the director of nursing (DON) stated she identified in the five weeks she was at the facility the nursing staff did not document as expected. The DON had not had time to educate the staff but had a nursing staff meeting scheduled for the near future. The DON expected nursing to assess behaviors and to create a resident centered care plan to minimize the behaviors.<br><br>A facility policy regarding mood/behavior assessment and care planning was requested but not received. | F 744 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00797 | A. BUILDING: _____ B. WING _____ | C 12/06/2023 |

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|---|---|---|---|---|
| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 12/4/23 -12/6/23 , a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found in compliance with the MN State Licensure.<br>The following complaints were reviewed.<br>H53297538C (MN98898). No licensing orders | 2 000 | | |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 12/22/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| 2 000 | Continued From page 1<br>were issued.<br>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | 2 000 | | |